CHESTERFIELD OPHTHALMOLOGY
Stephen M. Busch, D.O., F.A.O.C.O.
2385 Colony Crossing Place
Midlothian, VA 23112
(804) 739-2220

In accordance with proper HIPAA compliance, Chesterfield Ophthalmology, P.C. has provided a written Notice of Privacy Practices and Regulations (adaptive summary) and made a copy available to me upon my request.

SIGNATURE _____ Date: _____

As outlined in the Privacy Notice, I, _____ give permission for Chesterfield Ophthalmology, P.C. to allow the following person(s) to have access to any medical or financial information I receive under their care.

This information may be disclosed in person, or by written or phone correspondence, and includes accompanying me in the exam room for examination or treatment.

Name: _____ Relationship: _____

Contact Phone#: (____) _____

Name: _____ Relationship: _____

Contact Phone#: (____) _____

Name: _____ Relationship: _____

Contact Phone#: (____) _____

SIGNATURE _____ Date: _____