Eye Physicians & Surgeons, PC

PATIENT ACKNOWLEDGMENT FORM

Patient Acknowledgment of Understanding of Eye Physicians & Surgeons, PC's Privacy Practices

Patient's name: _____ Date of birth: _____

SSN: _____ Previous name: _____

I understand that the patient's health information is private and confidential. I understand that Eye Physicians & Surgeons, PC works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Eye Physicians & Surgeons, PC may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual

Eye Physicians & Surgeons, PC has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy and is attached to this Acknowledgment. I understand that I have the right to read the "Notice" before signing this Acknowledgment.

Eye Physicians & Surgeons, PC may update this Acknowledgment and "Notice of Privacy Practices". If I ask, Eye Physicians & Surgeons, PC will provide me with the most current "Notice of Privacy Practices".

Within this Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. These rights include, but are not limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication be by specified methods of communications or alternative location.

Eye Physicians & Surgeons, PC has established procedures which help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgments, and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist Eye Physicians & Surgeons, PC by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices".

Please complete this section if you wish to give us permission to discuss your health information with another individual.

I give Eye Physicians & Surgeons, PC permission to discuss my health information with the following individual(s):

_____

Name **Address**

_____

Name **Address**

My signature below indicates that I have been given the chance to review a current copy of Eye Physicians & Surgeons, PC 's "Notice of Privacy Practices" and gives permission to discuss my health information with individual(s) listed above.

_____ _____ _____

Date Time

_____

Relationship to patient if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)