HIPAA PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we <u>may not be allowed</u> to process your insurance claims.

I understand that Eye 2 Eye Care will use and disclose health information about me. I understand that my health information may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my demographics, health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may use and disclose my health information in order to:

- **Make decisions about and plan for my care and treatment.**
- **Refer to, consult with, coordinate among, and manage, along with other healthcare providers for my care and treatment.**
- **Determine my eligibility for a health plan or insurance coverage, and submit bills, claims, and other related information to insurance companies or others who may be responsible to pay for some or all of my health care.**
- **Perform various office, administrative, and business functions that support my physician's efforts to provide me with, arrange, and be reimbursed for quality, cost-effective health care.**

FINANCIAL RESPONSIBILITY: I acknowledge my duty to pay any deductibles, co-insurance, co-pays, and non-covered services.

IF PATIENT HAS A CONTACT LENS EXAM: I acknowledge that I have received and have access to my finalized contact lens prescription.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff, and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect may be provided. I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests. A copy of this signed, dated document shall be as effective as the original. My signature will also serve as a PHI document release should I request personal documents be sent to other attending doctors/ facilities in the future.

I AUTHORIZE <u>INFORMATION ABOUT MY HEALTH</u> BE CONVEYED VIA:

▢ **Cell Phone Confirmation** ▢ **Text Message to my Cell Phone** ▢ **Home Phone Confirmation**
▢ **Email Confirmation** ▢ **Work Phone Confirmation** ▢ **Fax Confirmation**
▢ **Any of the Above**

________________________________ ________________________________
Please *<u>print</u>* your name **Please *<u>sign</u>* your name**

________________________________ ________________________________
Legal Representative **Description of Authority**

____
Date

<u>Office Use Only</u>

As Privacy Officer, I attempted to obtain the patient's (or representative's) signature on this Acknowledgement but did not because:

▢ **It was emergency treatment** ▢ **I could not communicate with the patient**
▢ **The patient refused to sign** ▢ **The patient was unable to sign because**
▢ **Other (please describe)**

Signature of Privacy Officer: _______________________________________