Written Acknowledgement of Receipt of Notice of Privacy Practices

Patient Legal Name: _____ Date of Birth: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices. The HIPAA privacy rule gives individuals, parents or guardians the right to request a restriction on uses and disclosures of their (their child's) protected health information (PHI). The individual/parent/guardian is also provided the right to request confidential communication of PHI or other sensitive information be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

My signature will serve as a PHI document release should I request ReFocus Eye Health medical records be sent to other attending doctor(s) / facilities in the future. I also understand that I can contact the Privacy Officer, Kristen Madigan, at Kristen.Madigan@refocuseye.com, if I have further questions or complaints.

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO THE PATIENT'S HEALTH INFORMATION (This includes stepparents, grandparents, and any care takers – PHOTO ID REQUIRED). *You **DO NOT** need to fill this section out for your medical records to be sent to other physician offices.*

I hereby give permission to the person(s) listed below to receive confidential information about the care of the above-named patient.

Printed Name: _____ Relationship to Patient: _____
Contact Phone/Email: _____

Printed Name: _____ Relationship to Patient: _____
Contact Phone/Email: _____

[ ] Send a copy of any amended Notice of Privacy Practices by email: _____

_____ _____
Signature of Patient or Parent/Guardian/Personal Representative *Date*

_____
Printed Name of Patient or Parent/Guardian/Personal Representative

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and request for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual, parent, guardian or personal representative.

Office Use Only
I attempted to obtain the patient's (or representatives) 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 _____

Note: In an emergency, uses and disclosures of PHI for treatment, payment or healthcare operations may be permitted without prior consent.