OPHTHALMOLOGY ASSOCIATES, P.S.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

_____ ***(Initials)*** I have been offered a copy of Ophthalmology Associates, P.S.C.'s Notice of Privacy Practices.

_____ ***(Initials)*** I understand and consent to the use and disclosure of protected health information about myself for treatment, payment and health care operations.

If you would like to authorize another individual (e.g., spouse, other family member) to have access to your protected health information, please ask for a ***HIPAA Authorization Form.***

You have the right to a self-pay visit. If you so choose, we will not share your medical information with your insurance company. However, you will be responsible to pay the full balance for your exam and all testing. Please notify the staff if you would like this option.

_____

PRINT PATIENT'S NAME OR PERSON AUTHORIZED TO CONSENT FOR PATIENT

_____ _____

SIGNATURE **DATE**

IF PERSON CONSENTING IS OTHER THAN PATIENT:

_____ _____

PRINT NAME **RELATIONSHIP TO PATIENT**

FOR OFFICE USE ONLY

We have made every effort to obtain a written acknowledgment of receipt of our Privacy Notice from this patient but it could not be obtained because:

☐ The patient refused to sign

☐ Other _____

_____ _____

Employee signature *Date*