NOTICE OF PRIVACY ACKNOWLEDGMENT

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

I UNDERSTAND THAT, UNDER HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPPA), I HAVE CERTAIN RIGHTS TO PRIVACY REGARDING MY PROTECTED HEALTH INFORMATION. I UNDERSTAND THAT THIS INFORMATION CAN AND WILL BE USED TO:

- CONDUCT, PLAN, AND DIRECT MY TREATMENT AND FOLLOW-UP AMONG THE MULTIPLE HEALTHCARE PROVIDERS WHO MAY BE INVOLVED IN THAT TREATMENT DIRECTLY AND INDIRECTLY.
- OBTAIN PAYMENT FROM THIRD-PARTY PAYERS.
- CONDUCT NORMAL HEALTH CARE OPERATIONS SUCH AS QUALITY ASSESSMENTS AND PHYSICIAN CERTIFICATIONS.

I UNDERSTAND THAT I MAY REQUEST IN WRITING THAT YOU RESTRICT HOW MY PRIVATE INFORMATION IS USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS. I ALSO UNDERSTAND YOU ARE NOT REQUIRED TO AGREE TO MY REQUESTED RESTRICTION, BUT IF YOU DO AGREE, THEN YOUR ARE BOUND TO ABIDE BY SUCH RESTRICTIONS.

PLEASE LIST ANY PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes your spouse, children, step parents, grandparents and any care takers who can have access to this patient's records)

Name: ______________________ Relationship: _______________ Phone Number: _________________

Name: ______________________ Relationship: _______________ Phone Number: _________________

Name: ______________________ Relationship: _______________ Phone Number: _________________

Name: ______________________ Relationship: _______________ Phone Number: _________________

Can we leave automated appointment reminders on your home or cell phone? YES or NO

Can we leave messages letting you know your glasses and contacts are ready? YES or NO

Can any of the parties listed above pick up your glasses and contacts in the event you cannot? YES or NO

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for St. Clair Eye. A copy of this signed, dated document shall be as effective as the original. MY SIGNATURE WILL ALSO SERVE AS PROTECTED HEALTH INFORMATION DOCUMENT RELEASE SHOULD I REQUEST MY MEDICAL RECORDS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE.

_________________________________ _________________________________
Patient's Name (Please Print) Signature

_________________________________ _________________________________
Relationship to Patient Date