myeye consultants

Health Insurance Portability and Accountability Act (HIPAA)

ACKNOWLEGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(*Upon Request*)

Confidential Communication Disclosures

The HIPAA Privacy Rule gives individuals the right to request confidential communications; or that Protected Health Information is made by alternate means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (please circle all that apply):

Home Phone Cell Phone Email

Personal Information, including appointment information (circle one):

Leave message with detailed information

Leave message with call-back number only

Permission to leave detailed information with spouse/family member? **YES** **NO**

If yes, please list name(s): _____

Please list any additional ways we may or may not contact you that are not listed above:

_____

This acknowlegement page should be retained in patient's records. If this acknowledgement could not be obtained from patient, the reason must be documented below:

_____

My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Users and Disclosures of Protected Medical Information (Notice of Privacy Practices).

SIGNATURE: _____ **DATE:** _____

PRINT NAME: _____ **DOB:** _____