Liberty Hill Eye Associates, PLLC

PATIENT ACKNOWLEDGEMENT

Health Insurance Portability and Accountability Act (HIPAA)

Revised 02/20/2019

Our **Notice of Privacy Practices** provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this acknowledgement. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

The Summary of our Notice of Privacy Practices is posted in our main lobby. The complete Notice of Privacy Practices is also available in our main lobby for your review. If you would like to receive a copy of the Summary and complete Notice we have one available for you at the front desk.

If you wish for persons other than those released under normal operations as indicated in the Notice of receive confidential information that is now protected under this law you must release them in writing. Please indicate below spouse, or any family or friends whom you wish to be able to receive information about you. You may of course choose not to release anyone. You may also be more specific in your restrictions for the persons you have released, just provide that request in writing. Parents or Guardians of minor children do not need to be released.

Please be aware that our staff has to follow federal law on information that we release by phone and we may at any time choose not to release information of any kind by phone if we feel that the person requesting information is not authorized or we feel the information may be too sensitive to release by phone.

By signing this form, you are acknowledging that the Liberty Hill Eye Associates has made our **Notice of Privacy Practices** available to you for review and that we have offered you a personal copy.

Signature:_____ Date:_____

This acknowledgement was signed by: _____
Printed Name – Patient or Representative

Relationship to the patient (if other than the patient):_____

In front of _____
Practice Representative

The person(s) I have indicated below have my consent to receive the information that I have indicated, in addition to those person(s) already covered under the Notice of Privacy Practices

Please circle below the types of information we can release:

Name: _____ Medical Billing Appoints All Other:_____
Relationship:_____

Name: _____ Medical Billing Appoints All Other:_____
Relationship:_____