HIPAA PATIENT NOTIFICATION RECEIPT AND FAMILY ACCESS TO PROTECTED HEALTH INFORMATION

Patient full name: _____ Today's date: _____

Patient date of birth ____/____/_____

PATIENT NOTIFICATION RECEIPT

I understand that part of my healthcare, Eye Care Physicians & Surgeons, PC originates and maintains health records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning and carrying out medical care and treatment; a means of communication among the many health professionals who contribute to my medical care and treatment; a source of information for applying my diagnosis and surgical information to my bill; a means by which third party payers can verify that services were actually provided: and a tool for routine health care operations such as quality assurance, audits and assessments.

I have been provided with the **HIPAA Notice of Information Practices** that provides a complete description of Protective Health Information uses and disclosures. I understand that I have the right to complain, consent, object, restrict and/or request correction or amendment of my Protected Health Information. I understand that all such requests must be in writing and that Eye Care Physicians & Surgeons, PC is not required to agree to any corrections or restrictions that I may request. I understand that I may revoke any consent that I may have given, in writing, except to the extent that Eye Care Physicians & Surgeons, PC has already taken action in reliance thereon.

ACCESS TO PATIENT CARE AND PROTECTED HEALTH INFORMATION

I hereby give permission to the person(s) listed to inquire about information regarding my medical care. In order to obtain information by telephone, the party calling the practice must share date of birth.

Name	**Relationship**
Name	**Relationship**
Name	**Relationship**
Name	**Relationship**

In addition:

With this authorization, Eye Care Physicians & Surgeons, PC may call home or other designated location and leave a voice mail message, in person or by mail in reference to appointment, labs/test, insurance/billing items, forms, letters, general office correspondence, etc.

By signing this form, I am authorizing Eye Care Physicians & Surgeons, PC to use and disclose my Protected Health Information to the individuals I have listed on previous page to act on my behalf for healthcare information.

For specific information, I am aware I will need to complete the **Consent to Release Protected Health Information form**, prior to information being released, as specified in the HIPAA Notice of Information Practices.

I may revoke this authorization in writing at any time.

PRINT NAME _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN_____DATE_____