VILLAGE FAMILY eyecare

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received or been offered the HIPAA Notice of Privacy Practices which describes the uses and disclosures of my protected health information by the Practice and informs me of my rights with respect to my protected health information.

_____
Printed Name of Patient or Parent/Legal Guardian

_____ _____
Signature of Patient or Parent/Legal Guardian Date

FAMILY/FRIENDS DISCLOSURE AUTHORIZATION

It is the office policy of Village Family Eyecare not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment, (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers, please indicate that below, so that we may best serve you. If you do not want any of your medical information provided to a family member, please check (√) the line next to the "no" response. By signing below, you authorize the following people to receive information regarding your treatment or care and also give permission for them to pick up any items on your behalf such as glasses, contact lenses, etc. (If you wish to add names later on, please confirm this in writing, or call our staff.)

Spouse: _____ Phone: _____ ☐ Yes ☐ No
Parent: _____ Phone: _____ ☐ Yes ☐ No
Other: _____ Phone: _____ ☐ Yes ☐ No

_____
Printed Name of Patient or Parent/Legal Guardian

_____ _____
Signature of Patient or Parent/Legal Guardian Date

For Office Use Only:

☐ Patient refused to sign
☐ Unable to obtain signature
Reason: _____ Staff Initials: _____