



Patient Acknowledgment Form

Patient’s Name: _____ Date of Birth _____

SSN: _____ Previous Name: _____

I understand that the patient’s health information is private and confidential. I understand that Eye Care One protects patient’s privacy and preserves the confidentiality of the patient’s personal health information.

I understand that Eye Care One may use and disclose the patient’s personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. [*In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.]

Eye Care One has a detailed document called the “Notice of Privacy Practices”. It contains more information about the policies and practices protecting the patient’s privacy and is attached to this Acknowledgment.

Eye Care One may update this Acknowledgment and “Notice of Privacy Practices”. If I ask, Eye Care One will provide me with the most current “Notice of Privacy Practices”.

Within this Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. These rights include, but aren’t limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication be by specified methods of communications or alternative location.

Eye Care One has established procedures which help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgments, and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist Eye Care One by following these procedures if I choose to exercise any of my rights described in the “Notice of Privacy Practices”.

My signature below indicates that I have been given the chance to review a current copy of Physician’s Eye Center “Notice of Privacy Practices”.

Patient or legally authorized individual signature Date

Relationship to patient if signed by anyone other than patient

Authorization to treat a minor

I _____ hereby authorize Dr. _____
and whomever he/she may designate as his assistants to evaluate, diagnose
and/or treat as deemed necessary to the minor child _____.
Print child's name

Print Name

Signature Date