HIPAA Notice of Privacy Practices Consent/Acknowledgement

I understand that as a part of my health care, Seidenberg Protzko Eye Associates receives, originates, maintains, discloses, and uses individually identifiable health information, including, but not limited to, health records and other health information describing my health history, symptoms, medications, examination and test results, diagnoses, treatment, treatment plans, and billing and health insurance information. I understand that Seidenberg Protzko Eye Associates and its physicians, other health care professionals, and staff may use and disclose my protected health information for the purposes of treatment, payment and healthcare operations, or as otherwise required by law.

I have received a ***Notice of Privacy Practices*** that fully explains the uses and disclosures that Seidenberg Protzko Eye Associates will make with respect to my individually identifiable health information. I understand that I have the right to review the *Notice* before signing this consent. I also understand that Seidenberg Protzko Eye Associates reserves the right to change its notice and the practices. In the event of amendments, a revised *Notice* will be made available to me.

I understand that I do not have to consent to the use or disclosure of my individually identifiable health information for treatment, payment, and health care operations. If I do not consent, Seidenberg Protzko Eye Associates may refuse to provide me health care services unless applicable state or federal law requires Seidenberg Protzko Eye Associates to provide such services.

I understand that I have the right to request restrictions on the use or disclosure of my individually identifiable health information to carry out treatment, payment, or health care operations. I further understand that Seidenberg Protzko Eye Associates is not required to agree to the requested restrictions.

I understand that I have the right to request an alternative means of communications. I further understand that Seidenberg Protzko Eye Associates must honor this request if the *method of communication* is reasonable. Seidenberg Protzko Eye Associates may not ask why I want the alternate method of communication.

Please submit in writing any requests for restrictions, objections or alternate means of communication to the Privacy Officer.

I authorize Seidenberg Protzko to disclose protected health information to the following:

Name: ___________________________ Relationship: ______________ Phone: ______________

Name: ___________________________ Relationship: ______________ Phone: ______________

Name: ___________________________ Relationship: ______________ Phone: ______________

I understand that I may revoke this consent in writing but that the revocation will not be effective to the extent that Seidenberg Protzko Eye Associates has already taken action in reliance on my earlier effective consent.

Patient’s Name (Print): ___________________________________ Date: _____________________

Patient’s Signature (or Legal Representative): ____

Capacity of Legal Representative: ____