

TIDEWATER EYE CENTERS PATIENT ACKNOWLEDGEMENT FORM

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 Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

**Tidewater Eye Centers provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).**

The patient understands that:

- ❖ Protected health information may be disclosed or used for treatment, payment or health care operations
- ❖ Tidewater Eye Centers has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- ❖ Tidewater Eye Centers reserves the right to change the Notice of Privacy Policies
- ❖ The patient has the right to restrict the uses of their information but Tidewater Eye Centers does not have to agree to those restrictions
- ❖ The patient may revoke this Consent in writing at any time and all future disclosures will then cease

Family and Friends. It is the office policy of Tidewater Eye Centers, P.C. not to release confidential medical information regarding your treatment to family members of 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 (including but not limited to appointment times, prescription and payment) to be provided to family members, friends, or caretakers, or if you want us to leave a detailed message regarding your care please indicate that below. By signing below, you authorize the following people/message systems to receive detailed information regarding your treatment or care: (If you wish to add names later on, please confirm this in writing, or call our staff.)

**Spouse:** \_\_\_\_\_

**Parent:** \_\_\_\_\_

**Other:** \_\_\_\_\_

**May we leave a detailed message on your home answering machine?    Yes    No**

Alternative Communications. You are also entitled to specify alternative, reasonable means of communication, if you do not wish to be contacted by us in a certain way.

I hereby request the following means of contact only: \_\_\_\_\_  
\_\_\_\_\_

**Signature of patient OR person with power of attorney:** \_\_\_\_\_

**Printed name of party above:** \_\_\_\_\_

**Date:** \_\_\_\_\_      **Patient DOB:** \_\_\_\_\_

Received By: \_\_\_\_\_

Printed Name- TEC Representative