NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT FORM

I have been provided an opportunity to review The Notice of Privacy Practices in reference to the protection of medical records----(Copy of HIPAA Privacy Act Booklet is located at the front desk)

Patient Name _____

Signature _____

Relationship to Patient (if not SELF)_____

Date _____

****

(Fill out----------OR----------cross out if section not wanted)

****Section 1****

AUTHORIZATION TO SHARE MEDICAL INFORMATION

I authorize Toppino Eye Care to share my medical records with the following people:

_____ _____

Name **Relationship to Patient**

_____ _____

Name **Relationship to Patient**

****Section 2****

AUTHORIZATION TO LEAVE MEDICAL INFORMATION ON PATIENT'S VOICE MAIL

I authorize Toppino Eye Care to leave any medical information about myself on my voice mail.

_____ _____

Signature **Date**

I understand that if I want to change this authorization to include or exclude anyone or anything, at any time all I need do is fill out a new authorization form (like this one) and have it placed in my chart.

I further understand that any misrepresentation or erroneous information given by me will nullify this HIPAA Privacy Act form. And if I am signing for a minor, I signify/attest that I am the legal guardian for this patient, and have the right to sign this HIPAA Privacy Form.

_____ _____

Signature **Date**