

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the one-page NPP summary of key privacy rights, uses and disclosures from M. Hanif Peracha, M.D., P.C. (dba Eye Surgeons Associates) and understand that I may request a full copy of this privacy notice.

Patient's Printed Name

_____, 20_____
Signature of Patient (or Personal Representative*) Date of Signature

Personal Representative's Name (Printed) Relationship of Personal Representative

** The Personal Representative is the patient's decision maker if the patient cannot act for themselves. It can be the parent, legal guardian, health care surrogate, or other person.*

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

I wish to be contacted in the following manner (check all that apply):

- | | | |
|---|---|---|
| <input type="checkbox"/> Home telephone | <input type="checkbox"/> May leave a detailed message | <input type="checkbox"/> Only leave message with a call back number |
| <input type="checkbox"/> Work telephone | <input type="checkbox"/> May leave a detailed message | <input type="checkbox"/> Only leave message with a call back number |
| <input type="checkbox"/> Cell phone | <input type="checkbox"/> May leave a detailed message | <input type="checkbox"/> Only leave message with a call back number |
| | <input type="checkbox"/> Opt out of text messaging | |
| <input type="checkbox"/> Email _____ | | <input type="checkbox"/> Opt out of email messages |
| <input type="checkbox"/> May mail to my home address | <input type="checkbox"/> May mail to my work/office address | |
| <input type="checkbox"/> May fax to this number _____ | <input type="checkbox"/> Other _____ | |

Permission to Disclose

I permit the Practice to discuss and disclose my PHI to the following authorized individuals:

- | | |
|--|--|
| <input type="checkbox"/> Spouse _____ | <input type="checkbox"/> Adult Child(ren) _____ |
| <input type="checkbox"/> Parent(s) _____ | <input type="checkbox"/> Personal Representative _____ |
| <input type="checkbox"/> Caretaker _____ | |

Patient's Printed Name

_____, 20_____
Signature of Patient (or Personal Representative*) Date of Signature

Personal Representative's Name (Printed) Relationship of Personal Representative

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