# Written Acknowledgement of Receipt of Notice of Privacy Practices

Patient Legal Name: _____ Date of Birth: _____

*The undersigned acknowledges the receipt of a copy of the currently effective Notice of Privacy Practices. The HIPAA (Health Insurance Portability and Accountability Act) Privacy Rule gives individuals, partners, or guardians the right to request a restriction on uses and disclosures of the specified individual's protected health information (PHI). The individual/ parent/ guardian is also provided the right to request confidential communication of PHI or other sensitive information be made by alternative means (i.e. sending correspondence to the individual's office instead of the individual's place of residence).*

My signature will serve as PHI document release should I request ReFocus Eye Health medical records be sent to other attending provider(s)/ facilities in the future. I also understand that I can contact the Director of Quality, Safety, and Compliance, Rabia Hamid, at rabia.hamid@refocuseye.com, if I have any further questions or concerns.

**PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO THE PATIENT'S HEALTH INFORMATION**
(This includes stepparents, grandparents, spouses, children, caretakers, etc.). You ***DO NOT*** *need to fill this section out for your medical records to be sent to other physician offices.*

I hereby give permission to the person(s) listed below to receive confidential information about the care of the above-named patient.

Printed Name: _____ Relationship to Patient: _____
Contact Phone No.: _____ D.O.B: _____

Printed Name: _____ Relationship to Patient: _____
Contact Phone No.: _____ D.O.B: _____

Printed Name: _____ Relationship to Patient: _____
Contact Phone No.: _____ D.O.B: _____

_____ _____
*Signature of Patient or Parent/ Guardian/ Personal Representative* *Date*

_____
*Printed Name of Patient or Parent/ Guardian/ Personal Representative*

The HIPAA Privacy Rule requires healthcare providers to take reasonable steps to limit the use or disclosure of, and request PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual, parent, guardian, or personal representative.

**Note:** In an emergency situation, uses and disclosures of PHI for treatment, payment, or healthcare operations may be permitted without prior consent.