

Patient Name: _____

Date of Birth: _____

**ACKNOWLEDGMENT OF PRIVACY PRACTICES AND HIPAA DISCLOSURE
AUTHORIZATION FOR DES PERES EYE CENTER**

Receipt of Notice of Privacy Practices:

(Initial) I acknowledge I have received, or I have been provided the opportunity to receive a copy of Des Peres Eye Center's (DEC) Notice of Privacy Practices that explains when, where and why my protected health information may be used or shared by DEC.

HIPPA Disclosure Authorization:

(Initial) **I authorize DEC** to leave a message on my voicemail &/or other electronic means at the following number(s):

(Initial) **I authorize DEC** to provide the following person(s) with my protected health information:

Print Name: _____ Relationship to Patient _____ # _____

Print Name: _____ Relationship to Patient _____ # _____

Print Name: _____ Relationship to Patient _____ # _____

**ONLY INITIAL IN THIS BOX IF YOU DO NOT WANT YOUR INFORMATION
RELEASED**

(Initial) **I DO NOT authorize DEC** to disclose my protected health information to anyone other than myself, except as permitted by HIPAA as described in DEC's Notice of Privacy Practices. (ex: Your Insurance Company)

I understand the HIPAA Disclosure Authorization(s) above may be revoked in writing at any time; however, the revocation will not affect disclosures of information previously authorized.

SIGNATURE OF PATIENT (OR authorized person to sign for patient): _____
If Authorized signer, relationship to patient: _____

DATE OF SERVICE _____