DES PERES EYE CENTER

ACKNOWLEDGMENT OF PRIVACY PRACTICES AND
HIPAA DISCLOSURE AUTHORIZATION

Receipt of Notice of Privacy Practices:

_______ I acknowledge I have received or I have been provided the opportunity
(Initial) 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.

HIPAA Disclosure Authorization(s):

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

____

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

Print Name:__________________________ Relationship to Patient__________

Print Name:__________________________ Relationship to Patient__________

Print Name:__________________________ Relationship to Patient__________

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

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 Relationship to Patient Date