LODESTAR
FAMILY EYE CARE, PC

Acknowledgement of Receipt of Notice of Privacy Practices (HIPAA)

I acknowledge that I have received the *Notice of Privacy Practices* from Lodestar Family Eye Care, PC. I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the *Notice of Privacy Practices* from Lodestar Family Eye Care, PC.

Date:_____

Patient Name:_____Signature _____

If you are signing as a personal representative of the patient, please describe your relationship to the patient and the source of authority to sign this form.

Print Name:_____Relationship:_____

Source of Authority:_____

Receipt of Notice of Privacy Practices

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office. The ***Notice of Privacy Practices*** you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our ***Notice of Privacy Practices***, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information. This information may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for the purposes of payment includes: (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our ***Notice of Privacy Practices***. Our policy will be updated whenever our privacy practices change. You can get an updated copy here at the office. When you sign this consent document, you signify you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perform healthcare operations. You also signify that you have received a copy of our ***Notice of Privacy Practices***. You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment, or healthcare operations, but as described in our ***Notice of Privacy Practices***, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our ***Notice of Privacy Practices*** describes how to ask for a restriction.

Authorization for Disclosure of Information

I,_____, authorize Dr. Reynolds/Dr. Frank to disclose information regarding my health, medical records, testing, and procedures to the following individuals:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name: _____ Relationship: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- *Individual refused to sign*
- *Communications barriers prohibited obtaining the acknowledgement*
- *An emergency situation prevented us from obtaining acknowledgements*
- *Other (Please specify)*

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