ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below, I acknowledge that I have received Ophthalmology Associates Notice of Privacy Practices.

_____ Account# _____
Patient Signature

_____
Date

_____
Patient Declined to Sign / Employee / Date

Who may we give information to regarding your condition, treatment or diagnosis?

Name **Phone** **Relationship**

_____

_____

_____

_____

_____

Is there anyone who should never have this information:

_____

I can be contacted regarding appointment and medical information in the following methods:

☐ **Text Message to** _____

☐ **Email address** _____

☐ **Cell Phone** _____ **May we leave a message YES NO**

☐ **Home number** _____ **May we leave a message YES NO**

☐ **Work number** _____ **May we leave a message YES NO**

OPHTHALMOLOGY ASSOCIATES
PATIENT NOTICE OF PRIVACY PRACTICES

The protection of your health information is important to us at Ophthalmology Associates. We have available to you a comprehensive version of our Notice of Privacy Practices if you wish to read it in its entirety. We ask that you acknowledge your opportunity to review a full copy of our Notice of Privacy Practices by signing below. This notice can also be found on our website **www.fw2020.com**. The delivery of your health care services will in no way be conditioned upon your signed acknowledgement. If you have any questions about the Notice of Privacy Practices, please notify an Ophthalmology Associates physician or staff member.

Please Read the Following

I have been provided the opportunity to read the Notice of Privacy Practices at Ophthalmology Associates.

I understand that Ophthalmology Associates is committed to treating and using protected health information about me responsibly. In using this information, this office will comply with all state and federal laws pertaining to your privacy rights, including the Privacy and Security protections provided to you by the Health Insurance Portability and Accountability Act ("HIPAA").

I understand that my health record is the physical and legal property of Ophthalmology Associates, but the information belongs to me. I may have access to inspect, amend or obtain a copy of my health information. Costs will incur for copies of my records, and appointments must be made with the Privacy Officer to inspect, access, or amend my health information.

I understand that Ophthalmology Associates is required to maintain the privacy of my health information. Ophthalmology Associates will require my authorization to release my health information to outside sources with the **exception** of disclosures for purposes of **Treatment, Payment, and Healthcare Operations.** Your authorization will need to be in writing and it will be specific to the disclosure requested. Your authorization for use and disclosure of information, with the exceptions as referenced above, may be revoked in writing at any time. Please notify this office if you ever decide to revoke your consent.

If you believe that your privacy rights have been violated, you may submit a written complaint to our HIPAA Privacy Officer at the address below:

Ophthalmology Associates
1201 Summit Avenue
Fort Worth, TX 76102
Attn: My Le, Privacy Officer

Notice Revision Date: October 5, 2018