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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Patient Agreement to Receive Electronic Communication

You May Refuse to Sign This Acknowledgment

Patient Name: ______________________________ Date of Birth: ______________________

I agree that the practice may communicate with me electronically at the phone text # and/or email address below.

I am stating that the practice may use SMS Text (cell-phone texting) to send messages to my cellular device and/or use Encrypted Email to send Email messages account listed below, which may contain Protected Health Information.

I am aware that it is my responsibility to secure these text and email inboxes on any device that may be checking these accounts, and that the practice will not be held responsible if my Patient Information is observed by anyone other than myself. I acknowledge that the practice will always send Email communication using HIPAA-compliant encryption. I further acknowledge that once the information is received into my text or Email inbox that the information integrity and security is my sole responsibility. This practice uses the SecureAK HIPAA-compliant email encryption system which offers email replies to our messages to be encrypted at no cost or obligation to the original recipient. Our practice encourages recipients of our encrypted emails to use the free “reply” feature of SecureAK to make sure all email communications are encrypted.

I am responsible for providing the practice any updates to my phone text # and/or email address, including changes and or termination.

I can withdraw my consent to electronic communications by contacting the practice in person or by phone.

SMS Cellular Phone Text Number: ____________________________

Email Address (PLEASE PRINT CLEARLY) ____

Patient Signature:________________________________ Date:________________________