Ravine Eye Center

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

By signing this document I acknowledge that I have read and/or received a copy of the Ravine Eye Center HIPAA Notice of Privacy Practices.

_____ _____ ____/____/____

Printed Name Patient Signature Date

Ravine Eye Center Use Only_____

Date Acknowledgement received ____/____/____

OR

Reason acknowledgement not obtained_____

PATIENT DISCLOSURE INFORMATION

In general, the HIPAA privacy rule gives individules the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request that confidential communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual home.

I wish to be contacted in the following manner (check all that apply)

☐ **Home Telephone**_____

☐ OK to leave message with detailed information

☐ Leave message with call-back number only

☐ **Work Telephone**_____

☐ OK to leave message with detailed information

☐ Leave message with call-back number only

Cell/Other Telephone_____

☐ OK to leave message with detailed information

☐ Leave message with call-back number only

☐ **Written Communication**

☐ OK to mail to my home address

☐ OK to mail to my work/office address

☐ OK to fax to this number_____

☐ **Persons authorized to receive information**

_____Relationship_____

_____Relationship_____

_____Relationship_____

_____Relationship_____

☐ **I do not wish to share information**

_____ _____ ____/____/____

Printed Name Patient Signature Date

_____ ____/____/____

Witness Signature Patient Date of Birth