Acknowledgment of Notice of Privacy Practices / HIPAA

LEAGUE CITY EYECARE & EYEWEAR
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The law requires that LEAGUE CITY EYECARE & EYEWEAR make every effort to inform you of your rights related to your personal health information.

By my signing below, I acknowledge that:

____ I was given the opportunity to read, have read or had explained to me LEAGUE CITY EYECARE & EYEWEAR'S Notice of Privacy Practice prior to any services offered.

____ The Notice of Privacy Practice could not be read due to the emergent nature of the care and will be acquired when possible.

HIPAA
I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which I have been provided a copy, that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly, obtain payment from third party payers, and conduct normal healthcare operation such as quality assessments and physician certifications.

I authorize LEAGUE CITY EYECARE & EYEWEAR to release my personal health information to the following individuals:

_____ _____

_____ _____

My vision plan requests that all diagnoses related to any medical condition I may have be released to them. As a non-traditional disclosure, release of this information requires my specific authorization:

___ I authorize the release of medical information to my vision plan
___ I do not authorize release of medical information to my vision plan

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____ _____
Patient Signature Date

If you are signing as a personal representative of the patient, please indicate your relationship. If you are signing for a minor, you attest that you have legal authority to make medical decisions for the minor.

_____ _____ _____
Representative Signature Relationship to Patient Date