Pacific Eye Care Center

Privacy Practices Acknowledgment and Consent Form

☐ I have received your Notice of Privacy Practices and/or I have been provided an opportunity to review it.

☐ I agree that telephone messages regarding my appointments, prescription renewals, lab results, and all other Protected Health Information* ("PHI"), may be left for me on voicemail systems and answering machines at the following telephone numbers, in addition to any other means of contact provided to you by me:

☐ (_____) _____-_____ ☐ Home/Office/Cell _____

☐ (_____) _____-_____ ☐ Home/Office/Cell _____

☐ (_____) _____-_____ ☐ Home/Office/Cell _____

[If we need to contact you with Lab results, please place a check mark next to the preferred contact number, if any.]

☐ I agree that my PHI may be shared with my spouse.

☐ I agree that my PHI may be shared with the following other people:

Name	Phone Number	Date of Birth
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand that I can change any of the foregoing agreements, at any time, by giving written notice to ***Pacific Eye Care Center.*** My PHI may be further disclosed by such recipient for the purposes referenced above and that my PHI may no longer be protected by state and federal laws because I have authorized the release of such information. I also understand that if any harm results after the authorized release to such person(s) I will **INDEMNIFY** ***Pacific Eye Care Center*** and PMRG their contracted billing service of any damages.

*as *defined in the Health Insurance Portability and Accountability Act of 1996 and its regulations, as may be amended from time-to-time ("HIPAA")*

Patient Name (print):_____

Signature: _____ Date:_____

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and fill in the information below.

Parent/Guardian Name (print): _____ Relationship to Patient: _____