Ophthal	mic	Associates	
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Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name:	Date of Birth:				
I have been given a copy of Ophthalmic Associates <i>Notice of Privacy Practices</i> ("Notice"), which describes how my health information is used and shared. I understand that the Practice has the right to change this <i>Notice</i> at any time. I may obtain a current copy by contacting the Practice Privacy Officer.					
D : Depotions:	have been provided with a copy of the Notice of				
Signature of Patient or Personal Representative	e Date				
Print Name					
Personal Representative's Title (e.g., Guardian,	Health Care Power of Attorney)				
ture.	section if you are unable to obtain a signa- unable or unwilling to sign this Acknowledgement, or other reason, state the reason:				
Completed by:					
Signature of Practice Representative	Date				
Print Name and Title					
File Original in Patient's Health Care Record					

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Patient Consent to Disclose Protected Health Information Form

Patient Name:	Date:		
Date of Birth: Telephone N	Telephone Number:		
Address:			
Although not a requirement under HIPAA, patient cuss protected health information with certain indi when sharing personal health information is not in allowed to evaluate your request and make a dec	nthe best interest of the patient, the Practice is		
I give Ophthalmic Associates permission to di following person(s):	scuss my protected health information with the		
(Please print clearly.)			
Name	Relationship		
e a a			
a d			
Signature of Patient or Personal Representative	Date		
Print Name	2		
Personal Representative's Title (e.g., Guardian, I	Health Care Power of Attorney)		
Distribution of Copies: Original to Patient's Health Car	re Record, Copy to Patient.		