Acknowledgement of Receipt of Notice of Privacy Practices For

I hereby acknowledge that I have received the Notice of Privacy Practices for the above office.

_____

Signature: Patient's Name / Personal Representative (as defined by HIPAA) Date

_____

Description of Personal Representation and please attach copy of documentation.

Documentation of "Good Faith" Attempt to get acknowledgement signature.

- ☐ Document presented to patient, but patient refused to sign acknowledgement.
- ☐ Patient presented with an emergency situation and there was no time to give the Notice or receive a signature. Attempt to get give the Notice, and get any acknowledgement will be handled as soon as possible.
- ☐ Documentation was presented to the patient but a communication failure prevented us from receiving the acknowledgement.
- ☐ The documentation was mailed to the patient but never returned to us.
- ☐ Other _____

_____

Employee preparing document Date

_____

Employee signature _____

Authorization Form- General

This authorization form permits:
Name Irmo Eye Center
Address 101 Oak Park Drive
City/State/ Zip Irmo, SC 29063
to use or disclose protected health information listed in the description section below for the following patient:

Name _____ Birth Date _____
Address _____
City/State/ Zip _____

Entity or person to receive the information:
Name _____
Address _____
City/State/ Zip _____

Description of information to be used or disclosed: _____
_____
_____

Purpose of use or disclosure: _____
_____

Expiration date or event: _____
_____

Rights of the Patient

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address listed at the top of this form I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

_____Date _____
Signature of Patient or Personal Representative(as defined by HIPAA)

Description of Personal Representative's Authority (attach necessary documentation)
_____

****

Office Use Only:

Receiving Employee_____ Date received_____

☐ Copy given to patient