The Eye Clinic Inc.
Leaders In Comprehensive Eye Care

3545 Lincolnway East
Massillon OH, 44646

830 Amherst Rd SE, Suite 204
Massillon OH, 44646

6046 Whipple Ave., NW
North Canton OH,44720

Due to HIPPA laws we are not permitted to speak with anyone in regards to your care unless they are listed by our patient.

Please list the person(s) that you would allow us to speak to in regards to your personal medical information.

Name _____**Relationship** _____

Contact # ____-_____-_____

Name _____**Relationship** _____

Contact # ____-_____-_____

Name _____**Relationship** _____

Contact # ____-_____-_____

Name _____**Relationship** _____

Contact # ____-_____-_____

Patient Information I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been 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.
I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization shall be in effect until revoked by the patient.

_____ Date_____
Signature or Personal Representative

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

Notice Of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA) 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.
- ●Conduct normal healthcare operations such as quality assessments and physician certifications.

I have reviewed The Eye Clinic Inc.'s *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Acknowledgement of Receipt Of Notice of Privacy Practices

Patient Name & Address:

I understand that a copy of the Notice of Privacy Practices policy will be provided to me upon request.

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

(!) An emergency existed & a signature was not possible at the time.

<> The individual refused to sign.

(!) A copy was mailed with a request for a signature by return mail.

(!) Unable to communicate with the patient for the following reason:

<> Other:_____

Prepared By: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Signature_____ Date_____