

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I,_____ (print name), acknowledge that I have been informed by Willow Street Eye Care, LLC of the existence of their HIPAA Notice of Privacy Practices document.

I also acknowledge that I have been offered a copy of this document.

I am voluntarily signing this acknowledgement form.

- The patient/legal representative can receive a copy of the signed Acknowledgement form upon request.
- Should Willow Street Eye Care, LLC update or change their Notice of Privacy Practices, I, as the patient/legal representative, understand that I will be asked to sign a new Acknowledgement form.

SIGNATURES:

Patient/Legal Representative: _____ Date:_____

Practice Representative: _____ Date:_____

Please indicate where our office has permission to leave messages:

Home answering machine Cell phone voicemail Text

Other persons: _____ Do not leave messages

On occasion, patients have requested a copy of their glasses or contact lens prescriptions to be emailed to them**. Please indicate if you authorize us to use email for this purpose:**

YES NO

Authorized Use and/or Disclosure:

I hereby authorize Willow Street Eye Care, LLC to release medical, billing, claims, prescription information and any other information we deem relevant to your case to the persons and/or organizations listed below:

Spouse_____ Organization_____

Power of Attorney _____ Other _____

Emergency Contact Name and Daytime Phone Number:

Name:_____ Phone: _____