PALMETTO CATARACT & EYE SPECIALISTS

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used:

(1) For Treatment: We are permitted to use or disclose your health information to others in order to provide and plan proper medical care for you.

(2) For Payment: We are permitted to disclose health information about your treatment and services in order to submit bills for the care and services you received and to collect payment from you, your insurance company, or a third party payer.

(3) For Health Care Operations: We are permitted to use your health information to assess the care and the outcome in your case and others like it, in order to assure the highest quality of care for our patients. With this consent, Palmetto Cataract and Eye Specialists may call my home (or alternative location) and leave a message on voicemail or via e-mail in reference to any items that assist the practice in carrying out treatment, payment, or health care operations (such as appointment reminders, insurance items, laboratory results, clinical care questions, and so forth).

I understand your Notice to Privacy Practices containing a more complete description of the uses and disclosures of my PHI is available to me. I understand that this organization has the right to change its Notice of Privacy Practices from time to time, and that I may contact Palmetto Cataract and Eye Specialists at any time to obtain a current copy of the Notice of Privacy Practices. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Palmetto Cataract and Eye Specialists may decline to provide treatment to me.

Signature of Patient or Legal Guardian	Date
Print Patient's Name	
Print Legal Guardian's Name, if applicable	

Also, I **AUTHORIZE / DO NOT AUTHORIZE** (circle one) Palmetto Cataract and Eye Specialists LLC to release my protected health information to family members (please specify below).

My protected health information may be released to: _____

Palmetto Cataract and Eye Specialists USE ONLY

I attempted to obtain the signature of the patient or legal guardian in acceptance of the Notice of Privacy Practices Acknowledgement but was unable to do so as documented below.

Date: Initials: Reason: