RETINA MACULA SPECIALISTS

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

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

- Conduct, plan and direct any 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 (insurance companies)
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I may request a copy of your *Notice of Patient 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 pf Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

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

For patients who bring companions for their appointment: I understand that my private health information may be discussed at any time during any interaction between myself and the RMS staff. If I allow my companions to be present during such interactions, my companions may be private information. It is MY responsibility to exclude my companions from such conversations between myself and RMS staff if I do not wish my companions to be exposed to my private information.

Patient Name(print):_____

Signature:_____

Date:_____

I authorize RMS staff to leave messages pertaining to my appointments by the following methods and assume responsibility to notify them whenever this information changes: (RMS staff will not leave messages containing private medical information)

Home Phone/answering machine	_____Yes	___No
Work phone/voicemail:	_____Yes	___No
Cell/Phone/voicemail:	_____Yes	___No

I authorize access to my protected health information for the following persons(optionally):

Name:_____ Relationship:_____

Name:_____ Relationship:_____