

# Tuscarawas Eye Centre, Inc.

## HIPAA WRITTEN ACKNOWLEDGEMENT FORM

I am a patient of Tuscarawas Eye Centre, Inc. I hereby acknowledge receipt of Tuscarawas Eye Centre, Inc.'s Notice of Privacy Practices.

Name [please print]: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

OR

I am a parent or legal guardian of \_\_\_\_\_ [patient name]. I hereby acknowledge receipt of Tuscarawas Eye Centre, Inc.'s Notice of Privacy Practices with respect to the patient.

Name [please print]: \_\_\_\_\_

Relationship to Patient:  Parent  Legal Guardian

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## PATIENT COMMUNICATION FORM

A. Family and Friends. It is the office policy of Tuscarawas Eye Centre, Inc. not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below, so that we may best serve you. If you do not want any of your medical information provided to a family member, please check (✓) the line next to the "no" response. **By signing below, you authorize the following people to receive information regarding your treatment or care.** (If you wish to add names later on, please confirm this in writing, or call our staff.)

_____	_____ yes	_____ no
_____	_____ yes	_____ no
_____	_____ yes	_____ no
_____	_____ yes	_____ no

B. Alternative Communications. You are also entitled to specify alternative, reasonable means of communication, if you do not wish to be contacted by us in a certain way.

I hereby request the following means of contact only: \_\_\_\_\_

**PRINTED NAME** \_\_\_\_\_

**Patient/Parent/Guardian Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

FOR OFFICE USE

Changes to above, authorized by patient over phone:  
Change

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Acct #: \_\_\_\_\_

Date                      Staff Initials

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_