CATARACT
CONSULTANTS PA

Laura L. Harris, M.D., F.A.C.S.

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE

1. I acknowledge that I have received or have been offered a copy of Cataract Consultants, PA Notice of Privacy Package, effective February 13, 2008._____(Initial)
2. I acknowledge my rights and have been offered the option to request to receive communications of my personal health information by alternative means or at alternate locations. I understand that Cataract Consultants, PA may refuse to accommodate my request if it is not reasonable._____(Initial)
3. Is there a family member or friend that you will allow us to leave messages with or release billing or medical information to?_____or None.

*A current Notice of Privacy Practices for Cataract Consultants, PA is also available at the check-in counter.

RIGHTS OF THE PATIENT

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address below. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that the information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may be no longer protected by federal or state law. Any information received by this office for our own use will continue to be protected by the Federal Privacy Rule. I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document by written notification to the address below. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

_____ _____

Signature of Patient or Representative Date

_____

Print Name

_____

Relationship or Representative / Authority to act on behalf of Patient

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