Ophthalmology Consultants of Fort Wayne, P.C.

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HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) PRIVACY RECEIPT ACKNOWLEDGEMENT

I acknowledge that a copy of the (HIPAA) Notice of Privacy Practices has been provided to me by Ophthalmology Consultants of Ft. Wayne, P.C. and I understand that I have the right to review the Notice of Privacy Practices prior to signing this document. My signature acknowledges only that I have received or have been offered a copy of the (HIPAA) Notice of Privacy Practices.

Ophthalmology Consultants of Fort Wayne, P.C. reserves the right to change the privacy practices that are described in the (HIPAA) Notice of Privacy Practices.

Printed Name of Patient _____ Date of Birth _____

Signature of Patient _____

Printed Name of Personal Representative _____ Date of Birth _____

Signature of Patient Representative _____

Description of Personal Representative's Authority _____

The above named patient or personal representative of the patient was given Ophthalmology Consultants of Fort Wayne, P.C's (HIPAA) Notice of Privacy Practices on the date indicated, but either refused to sign the acknowledgement or did not return the acknowledgement.

Signature and Title of Person Providing the HIPAA Notice of Privacy Practices

Signature _____ Title _____

CONSENT TO RELEASE INFORMATION: This consent form allows Ophthalmology Consultants of Fort Wayne, P.C. to use and disclose information about me protected under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. I understand that by this consent, I am allowing Ophthalmology Consultants of Fort Wayne, P.C. to release my protected health information to the following individuals. I also understand that my health information is subject to verification of identity of the individual(s) I authorized prior to disclosure. Ophthalmology Consultants of Fort Wayne, P.C. is not responsible for any disclosures made by the following individuals:

Name	Relationship	Identifier (i.e. date of birth)

I understand that at any time I have the right to revoke this consent and that I must do so in writing, but that Ophthalmology Consultants of Fort Wayne, P.C. may still use information to complete any actions that it began prior to my revoking consent.

Printed Name of Patient _____ Date _____

Signature of Patient _____