HIPAA PRIVACY
REQUEST ON USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

Carolina Eye Care on Merrimon OD PA

NOTICE TO PATIENT: Your request is applicable only to the information maintained by the Practice. If you would like restrictions to be maintained by any other health care provider or health plan, you must submit a separate request to the other health provider or plan.

Patient Name ____________________________Date of Birth________________________

Use and Disclosure of My Protected Health Information

I request the Practice named above to allow disclosure of my protected health information relating to treatment, payment and health care operations, and/or disclosures to family members or others involved in my care as follows:

____

____

____

____.

Check one: The time period for the restrictions is: [__] From ___________ to _______________; or [__] Until I notify the Practice in writing of termination.

____ ___________________________
Signature of Patient or Legal Guardian or Personal Representative Date

____
Print Name of Guardian or Representative

Relationship to Patient__________________________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ____, (Please print full legal name here) have been presented with the NOTICE OF PRIVACY PRACTICES of CAROLINA EYE CARE ON MERRIMON and have been offered a copy of such policy to keep for my records.

_____________ (Please initial here) I hereby acknowledge that I have been provided with a copy of the policy.

OR

_____________ (Please initial here) I hereby refuse to acknowledge receipt of the policy. I understand that even though I may refuse to sign this acknowledgement, Carolina Eye Care on Merrimon may still provide treatment to me.

FOR OFFICE USE ONLY

Carolina Eye Care on Merrimon attempted to obtain the written acknowledgement of receipt of the Notice of Privacy Rule on _______________, but acknowledgement could not be obtained because:

_____________ Patient or patient's legal representative refused to sign.
_____________ Patient or patient's legal representative could not be communicated with sufficiently to obtain acknowledgement.
_____________ Emergency circumstances prevented securing acknowledgement.
_____________ Other:____

____
Signature of Provider Representative   Date