Notice of Privacy Practices Acknowledgment HIPAA 1 212

The Spokane Eye Clinic has a responsibility to protect the privacy of your health care information and to provide a Notice of Privacy Practices that describes how your health care information may be used and disclosed, how you can access your health care information, and whom to contact if you have questions, concerns, or complaints.

We may change the Notice of Privacy Practices at any time, and you may contact our Privacy Officer at (509) 456-0107 to obtain a current copy of the Notice of Privacy Practices or to ask questions.

By my signature below, I agree that I have received the Notice of Privacy Practices of the Spokane Eye Clinic.

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Printed name of patient Date of Birth

____

Patient or legally authorized individual's signature Date Time

____

Printed name if signed on behalf of the patient Relationship (parent, legal guardian, power of attorney, or kinship caregiver)

This form will be retained in your medical record.

For Office Use Only

Office staff complete below:
I have documented the receipt of this form in the patient's EPM chart.

Date: _____________________ Staff Initials: _______________________