



Receipt of Notice of Privacy Practices

Lifetime Eyecare's **HIPAA NOTICE OF PRIVACY PRACTICES** (Health Insurance Portability and Accountability Act) is posted in our reception area and also available as a printed copy upon request. We will follow those policies in maintaining & disclosing your protected information.

I have been provided an opportunity to review the Lifetime Eyecare HIPAA Notice.

Patient Name (print) _____ (DOB) _____

Signature of Patient Parent Personal Representative _____ Date _____

THIS ACKNOWLEDGEMENT WILL REMAIN IN EFFECT UNLESS OTHERWISE REVOKED IN WRITING

(PLEASE CIRCLE)

- May we phone, mail, email, and/or send text messages to confirm appointments or notify you of product availability? **YES NO**
- May we leave a message on your answering machine at home or on your cell phone? **YES NO**
- May we call you at work? *(We will only leave messages on a voice mail.)* **N/A YES NO**
- We will discuss your medical condition/s and billing in the presence of any person accompanying you to your visit. Is this acceptable? **YES NO**

I grant permission to disclose health or billing information to the individuals listed below:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I request the following restrictions to the use or disclosure of my health information:

Restrictions: _____

Please contact Lisa Poland, Office Manager, at 301-777-7777 with any questions or concerns about your protected health information.