Tony Smith, M.D.
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Eye Physicians and Surgeons

Eye Physicians of Elizabethtown

Ophthalmology

1109 Woodland Drive
Elizabethtown, KY 42701
Phone: (270) 765-6066
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ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name (Print): _____ **Date of Birth**: _____

Our Notice of Privacy Practices ("Notice") provides information about how we may use and disclose Protected Health Information ("PHI") about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Acknowledgment. The Practice reserves the right to change the Notice of Privacy Policies. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, except in certain limited instances, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of PHI about you for non-subsidized treatment, payment and health care operations, electronic medication history thru New Crop, automated reminder calls/texts/emails and for other purposes as permitted or required by law. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that: PHI may be disclosed or used for treatment, payment or health care operations, or for other purposes permitted or required by law. However, we will obtain from you a separate written authorization for "subsidized" disclosures, meaning disclosures involving product or service with respect to which the Practice receives remuneration from a third party.

I was offered a copy of Eye Physicians of Elizabethtown Notice of Privacy Practice effective 9-23-2013.

Patient or Representative Signature: _____ **Date**: _____

Relationship to Patient (if other than patient): _____

Patient Authorization for Personal Representative

Purpose of request: I authorize the practice to disclose or provide my protected health information (PHI) to the following individual(s) who is authorized to act as my personal representative for the purposes of receiving all PHI about myself. As my designated personal representative, he/she may exercise my right to inspect, copy and request amendments to my PHI. He/she may also consent or authorize the use or disclosure of my PHI.

- **Description of information to be disclosed**: I authorize the practice to disclose all of my PHI to my designated personal representative(s).
- **Expirations or termination of authorization**: This authorization will remain in effect until terminated by you, your personal representative or another individual(s) of legal entity authorized to do so by court order or law.
- **Right to revoke or terminate**: As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Officer. This can be done in-person or by mailing a request to Eye Physicians of Elizabethtown.
- **Redisclosure**: We have no control over the person(s) you have listed as your personal representative. Therefore, your protected health information disclosed under this authorization, will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.

Print Name(s) of Personal Representatives who you want to have access to your PHI as described above:

_____

Patient or Representative Signature: _____ **Date**: _____

Relationship to Patient (if other than patient): _____