ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

The law requires that Mt. Pleasant Eye Care Center, P.A. make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

I have either read, declined to read, or had explained to me Mt. Pleasant Eye Care Center, P.A.'s Notice of Privacy Practices. In any of the aforementioned cases, I **AGREE** to continue my care with Mt. Pleasant Eye Care Center, P. A. under the terms and specifications set forth in Mt. Pleasant Eye Care Center, P.A.'s Notice of Privacy Practices.

Otherwise, the Notice of Privacy Practices of Mt. Pleasant Eye Care Center, P.A. could not be read due to the emergent nature of the care of other reason described as

____

____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

____ ________________________
Patient Date

If you are signing as a personal representative of the patient, please indicate your relationship.

________________________________ ________________________________
Representative Relationship to Patient

By signing below, I am acknowledging that I **DECLINE** to accept the terms and specifications set forth in Mt. Pleasant Eye Care Center P.A.'s Notice of Privacy Practices and fully understand that this necessarily, by default, results in the unfortunate inability of Mt. Pleasant Eye Care Center, P.A. to satisfactorily serve my health care needs.

____ ________________________
Patient Date

If you are signing as a personal representative of the patient, please indicate your relationship.

________________________________ ________________________________
Representative Relationship to Patient

The HIPPA privacy rule gives individuals the right to request confidential communications concerning their protected health information (PHI), or that it is permissible to communicate PHI to alternate individuals.

Please specify your preferences below:

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER: (Check ALL That Apply)

☐ CELL Phone #____

☐ OK to leave DETAILED Message ☐ OK to leave a CALL BACK number ONLY.

☐ HOME Phone #____

☐ OK to leave DETAILED Message ☐ OK to leave a CALL BACK number ONLY.

☐ WORK Phone #____

☐ OK to leave DETAILED Message ☐ OK to leave a CALL BACK number ONLY.

I AUTHORIZE MPECC, PA TO DISCUSS MY MEDICAL HISTORY AND RELEASE ANY AND ALL MEDICAL OR BILLING INFORMATION TO THE FOLLOWING INDIVIDUALS: (Check ALL That Apply)

☐ Spouse / Name_____________________________________ Phone # _______________________

☐ Parent / Name _____________________________________ Phone # _______________________

☐ Other Name ______________________ Relationship_____________ Phone #_______________

☐ NO ONE OTHER THAN MYSELF