OOLTEWAHEYE SPECIALISTS

CLEVELANDEYE CLINIC

EXCELLENCE · INTEGRITY · COMPASSION

ATHENSEYE ASSOCIATES

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my Protected Health Information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications. I

received, read and understand your ***Notice of Privacy Practices*** containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its ***Notice of Privacy Practices*** from time to time and that I may contact this organization at any time to obtain a current copy of the ***Notice of Privacy Practices***.

Signature of Patient or Legal Guardian: _____Date: _____

Print Patient's Name: _____

Print Legal Guardian's Name: _____

Consent to Release Information

I designate the following representative(s) who the doctor or clinical staff can communicate with on my behalf. If I do not designate anyone, I understand that the doctor or clinical staff will be unable to speak with anyone regarding my medical condition.

Name:_____Relationship:_____Phone #:_____
Name:_____Relationship:_____Phone #:_____
Name:_____Relationship:_____Phone #:_____

Signature on File:

Signature of Patient or Legal Guardian:_____ Date:_____
Print Patient's Name:_____
Print Legal Guardian's Name:_____

PRACTICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date:	Initials:	Reason: