ACKNOWLEDGEMENT OF HIPAA NOTICE OF PRIVACY PRACTICES

I understand that in an attempt to protect the privacy of my identifiable health information, Kennedy Eye Care has established a Privacy Policy and guidelines for Privacy Practices within their office. This information details the use and/or disclosure of information contained in my personal medical/optometric records kept for the purposes of diagnosis, treatment, payment and health care operations. In accordance with HIPAA Regulations, a copy of Kennedy Eye Care's HIPAA Notice of Privacy Practices has been made available to me while in the office today. Should I choose to have a personal copy; one will be given to me at no charge.

I HEREBY AUTHORIZE THE FOLLOWING PERSON(S) TO HAVE ACCESS TO MY FINANCIAL AND MEDICAL RECORDS: (for example: family and /or friends)

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Print Patient's Full Name ______________________________________

Signature ______________________________________ Date ____________________