HIPPA Acknowledgement Form Blue Vision Center

First Name

Last Name

Relationship to the patient

☐ Patient ☐ Spouse ☐ Guardian

Name If Not The Patient

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information understand that this information can and will be used to:

- Conduct plan and direct my treatment and follow up care among the multiple health care providers who may be involved in that treatment directly or indirectly

- Obtain payment from designated third-party payers.

- Conduct normal health care operations such as quality assessments or evaluations emphasized physician certifications

I have been given the right to review the practice Notice of Privacy Practices (NOPP) prior to signing this consent. I understand that the practice has the right to change its NOPP from time to time and that I may contact the practice at any time to obtain a current copy of the NOPP

I understand that I may request in writing that the practice restricts how my private information is used or disclosed to carry out treatment, payment, or health care operations, I also understand the practice is not required to agree to my requested restrictions but if it does agree that is bound to abide by such restrictions

I understand that I may revoke this consent in writing that any time except to the extent that the practice has taken action relying on this consent

Client Signature

Date