**HIPAA – NOTICE OF PRIVACY PRACTICE**

**At Signature Eye Care we make every effort to inform you of your rights related to your personal health information. The HIPAA notice of privacy practice protects your privacy rights. We will not release your information unless it directly involves your care. *A full explanation of our policy is available upon request*.**

By signing below, I acknowledge that:

***(Please check only one)***

* I have read or had explained to me Signature Eye Care’s Notice of Privacy Practice and **agree to have my care with Signature Eye Care** under said terms.

***OR***

* I have read or had explained to me Signature Eye Care’s Notice of Privacy Practice and **do not wish to continue my care with Signature Eye Care** under said terms.

***OR***

* I have more questions about the HIPAA – Notice of Privacy Practice

**ACCESS TO HEALTH RECORDS**

**I further authorize the following people access to my health records:**

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Name Relationship to Patient

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Name(s) Relationship(s) to Patient

**NOTICE OF INSURANCE ACCEPTANCE**

**(Only applies to those using insurance)**

At Signature Eye Care, we strive to understand, accept, authorize, and properly process your insurance benefits. We will work diligently to resolve any possible difficulties with your insurance company. Ultimately, you are the responsible party for all services and products rendered.

By signing my name below, I acknowledge that I have read or had explained to me Signature Eye Care’s Notice of Privacy Practice.

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Patient’s Printed Name

**X\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient (Or Guardian of Patient) Signature Date