IOWA EYE
CENTER

Medical | Surgical | Optical

## ACKNOWLEDGEMENT OF PRIVACY PRACTICES POLICY

I acknowledge that I am aware of the Provider's Notice of Privacy Practices posted at Iowa Eye, P.C., which summarizes the ways my identifiable health information may be used and disclosed and states my rights with respect to my medical information. I understand that Iowa Eye, P.C., has the right to revise these information practices and to amend the Notice of Privacy Practices. I understand that in the event that the Notice is revised, the revised Notice will be posted at Iowa Eye, P.C., and I also understand that I may obtain a current Notice of Privacy Practices at any time from Iowa Eye, P.C.

_____ _____

Signature of Patient/Guardian/Representative Date Signed

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If Guardian/Representative – State Relationship to Patient

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Sometimes family members or friends call us to see if they can discuss your health care, schedule appointments for you or help you with insurance or billing issues. In order for us to protect your privacy and follow HIPAA regulations we are unable to discuss your case with any family members or friends without your consent. This form will allow us to talk to your family or friends if you wish.

## CONSENT TO RELEASE INFORMATION

PATIENT NAME: _____
DATE OF BIRTH: _____
CHART NUMBER: _____

You have my permission to discuss my case as needed or requested with the following individuals:

NAME: _____ RELATIONSHIP: _____
NAME: _____ RELATIONSHIP: _____
NAME: _____ RELATIONSHIP: _____
NAME: _____ RELATIONSHIP: _____
NAME: _____ RELATIONSHIP: _____

I understand that any information released in reliance upon this consent shall not constitute a breach of my rights to confidentiality.
I understand that I may revoke or change this consent at any time by contacting the Practice Administrator at Iowa Eye Center.

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Signature of Patient or Legal Guardian Date