BILLINGSLEY EYE CARE

Patient's name: ____ Date: __________________

Date of birth: ____________

Patient Acknowledgment of Notice of Privacy Practices

I understand that the patient's health information is private and confidential. I understand that Billingsley Eye Care works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

Billingsley Eye Care may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual.

Billingsley Eye Care has a detailed document called the "Notice of Privacy Practices." It contains more information about the policies and practices protecting the patient's privacy and is attached to this Acknowledgment. I understand that I have the right to read the "Notice" before signing this Acknowledgment.

I give Billingsley Eye Care permission to discuss my health information with the following

individual(s):

_________________________; ________________________; _________________________

Name; Relationship; Phone Number

_________________________; ________________________; _________________________

Name; Relationship; Phone Number

May we contact in case of emergency? Yes___ No ___

My signature below indicates that I have been given the chance to review a current copy of Billingsley Eye Care "Notice of Privacy Practices" and gives permission to discuss my health information with

individual(s) listed above.

____ ______________________

Signature of Patient (or parent/guardian if a minor) **Date**