



ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Summary:

The law requires Eyecare of Rigby to make every effort to inform you of your rights related to your personal health information. You may request a full copy of our Notice of Privacy Practices.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record.
- Correct your paper or electronic medical record.
- Ask us to limit the information we share.
- Get a list of those with whom we've shared your information.
- Get a copy of our Notice of Privacy Practices.
- Choose someone to act for you.
- File a complaint if you believe your privacy rights have been violated.
- Tell us how we may use to share your information with family and friends about your condition.

Our Uses and Disclosures

We may use and share your information as we:

- Treat you.
- Run our organization.
- Bill for your services.
- Help with public health and safety issues.
- Respond to lawsuits and legal actions.

By my signing below, I acknowledge that:

- I have read or had explained the Notice of Privacy Practices. I am signing it voluntarily.
- I have read or had explained the Notice of Privacy Practices. I do not wish to continue my care with Eyecare of Rigby under said terms.

Patient's Name _____ Date _____

I give permission to discuss my personal health information with:

Name _____ Phone _____ Relationship _____

If you are signing as a personal representative of the patient, please indicate your relationship

Representative _____ Relationship _____