

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

By signing below, I acknowledge that I have been given the opportunity to read and receive a copy of MidWest Eye Center's Notice of Privacy Practices ("Notice").

Date _____

Signature (Patient or Authorized Representative) _____

Printed (Patient or Authorized Representative) _____

<p>FOR OFFICE USE:</p> <p>If you are unsuccessful in obtaining a signature from the patient or authorized representative explain circumstances below.</p> <p>_____</p> <p>Signature Staff Member _____ Date _____</p>
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AUTHORIZATION FOR THE USE OR RELEASE OF HEALTH INFORMATION

I authorize MidWest Eye Center, Inc to release (**circle type of information**) **Financial Medical All** my protected health information to (persons or person) _____

This Authorization shall expire on _____ year _____

I understand that I have the right to cancel this Authorization, if the cancellation is in writing, except if

- MidWest Eye Center, Inc. has already released information prior to cancellation.
- The cancellation must be in writing to the address listed below.

I understand that my medical and account information that is used or released under this document may be subject to re-use by the person or persons receiving the information, and the privacy of my medical and account information will no longer be protected by the law.

Treatment cannot be withheld for refusing to sign this authorization unless the following is true:

- The reason for the exam and authorization is to be included in a medical research study, or
- The sole purpose of the exam is to send a third party the results of the exam after obtaining this agreement. For Example An employer requested exam for prospective employees, or a school exam.

Messages with medical financial information may be left on voice mail at the following number(s).

- home phone _____ cell phone _____
- work phone _____ none of the above

By signing this agreement, I acknowledge that I have read and understand the terms. Further, I authorize the use or release of my medical and account information (Protected Health Information) in accordance with the terms of this Agreement.

Signature (Patient) _____ Date _____

Signature (Authorized Representative) _____ Date _____

Printed _____

Description of Authorized Representative's authority to sign for the patient: _____

Signature (Witness) _____ Date _____

For cancellation in-whole or in-part write to:
HIPAA Contact Person
MidWest Eye Center, Inc.
802 Scott Street
Covington, KY 41011