

PLEASE SIGN AFTER READING NOTICE OF PRIVACY PRACTICES ATTACHED

**Charlotte Ophthalmology Clinic
Patient Acknowledgment of having read or been read the
Notice of Privacy Practices**

I have been provided the opportunity to read, or it has been read to me, the Notice of Privacy Practice at Charlotte Ophthalmology Clinic.

I understand that Charlotte Ophthalmology Clinic is committed to treating and using protected health information about me responsibly.

I understand my right as it relates to my records at Charlotte Ophthalmology Clinic and understand how information about me may be used or disclosed.

I understand that my health record is the physical and legal property of Charlotte Ophthalmology Clinic, but the information belongs to me. I may have access to inspect, amend or obtain a copy of my health information. Costs will incur for copies of my records, and appointments must be made with the Privacy Officer to inspect, access or amend my health information.

I understand that Charlotte Ophthalmology Clinic is required to maintain the privacy of my health information. Charlotte Ophthalmology Clinic will require my authorization to release my health information to outside sources with the exception of disclosures for purposes of Treatment, Payment and Healthcare Operations. These may include: access to my health information by Charlotte Ophthalmology Clinic staff and physicians; billing to myself or a third-party payer; in addition, business associates of Charlotte Ophthalmology Clinic may, from time to time, have access to my health information, but, I am assured that proper Business Associates Agreements are in place, insuring the protection of my health information; upon the physician's best judgment, we may disclose to a family member, relative or close personal friend or any other persons you identify, health information relevant to that person's involvement in my care; may be used for research data; funeral directors; organ procurement; marketing; FDA; public health or legal authorities; and/or law enforcement purposes.

Charlotte Ophthalmology Clinic may call me with appointment reminders, cancellations and may leave voice mail messages at my home or place of employment.

I have read and understand the Notice of Privacy Practices of Charlotte Ophthalmology Clinic.

Patient Signature

Date

Witness

I _____ authorize the release of medical information to:

Name: _____

Relationship: _____

Name: _____

Relationship: _____