BUCKS-MONT EYE ASSOCIATES

NOTICE OF PRIVACY PRACTICES-ACKNOWLEDGMENT

We keep a record of the health care services we provide you. You may ask to see a copy of that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our office.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information. You may obtain a copy of this at any time.

I authorize the disclosure of my protected Health Care Information, including billing/financial information, to the persons listed below. This authorization will remain in effect until revoked.

NAME: _____ NAME: _____

PHONE: _____ PHONE: _____

RELATIONSHIP: _____ RELATIONSHIP: _____

☐ Caregiver ☐ Emergency Contact ☐ Next of Kin ☐ Caregiver ☐ Emergency Contact ☐ Next of Kin

As a patient at our practice, from time to time we may need to communicate with you. To preserve your privacy, please indicate your preferred method for us to communicate medical information to you:

☐ Do **NOT** leave any medical information on my answering machine or voicemail

☐ I give my permission to Bucks-Mont Eye Associates to leave medical information on my answering machine or voicemail at the numbers listed: ☐ **Home Phone** ☐ **Cell Phone** ☐ **Work Phone**

By my signature below, I acknowledge receipt of the Notice of Privacy Practices.

X_____ _____

Patient Signature (or signature of legally authorized individual) Date

_____ _____

PRINT Patient name Date of Birth

_____

PRINT name if signed on behalf of the patient