NORTH TEXAS OPHTHALMIC PLASTIC SURGERY

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICE

I understand I may obtain a copy of this practice's Notice of Privacy Practices, which provides me with a complete description of the uses and disclosures of certain health information, by request or contacting www.hhs.gov/ocr/hipaa/. I understand that I am entitled to receive a copy of this document.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature ___________________________________ Date ________________________
Name of Patient or Personal Representative

Relationship to Patient (If signed by a personal representative of patient):_____________

The following persons can have access to protected health information on a routine basis. I give permission for NORTH HEXAS OPHTHALMIC PLASTIC SURGERY to share my protected health information with:

Name	Relationship	Contact Number
Name	Relationship	Contact Number
Name	Relationship	Contact Number
Name	Relationship	Contact Number