HAMILTON MILL EYE CARE
PATIENT HIPPA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I. **Acknowledgment of Practice's *Notice of Privacy Practices:***

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices and agree to its terms.

II. **Designation of Certain Relatives as My Personal Representative:**

I agree that Hamilton Mill Eye Care may disclose certain information of my healthcare to a Personal Representative of my choosing since such person is involved with my healthcare or payments. In that case, Hamilton Mill Eye Care will disclose only information that is directly relevant to the person's involvement with my healthcare or payments.

Print Name: _____
Print Name: _____
Print Name: _____

III. **Request to Receive Confidential Communications by Alternative Means:**

As provided by Privacy Rule Section 164.522(b), I hereby give permission to Hamilton Mill Eye Care to leave messages for me by the alternative means that I have listed below.

Home Telephone Voicemail	YES	NO
Work Telephone Voicemail	YES	NO
Cell Phone Voicemail	YES	NO
Other: _____	YES	NO

_____ _____

Name of Patient (Print) Signature Date

_____

Witness