PATIENT ACKNOWLEDGMENT FORM

Patient Acknowledgment of Understanding of Medical Eye Associates, PA, s Privacy Practices

Patient's name: _____ Date of birth: _____

SSN: _____ Previous name: _____

I understand that the patient's health information is private and confidential. I understand that Medical Eye Associates, PA, its subsidiaries and/or divisions, (hereafter referred to as MEA), works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that MEA may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. [*In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.]

MEA has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy and is attached to this Acknowledgment. I understand that I have the right to read the "Notice" before signing this Acknowledgment.

MEA may update this Acknowledgment and "Notice of Privacy Practices". If I ask, MEA will provide me with the most current "Notice of Privacy Practices".

Within this Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. These rights include, but aren't limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication be by specified methods of communications or alternative location.

MEA has established procedures which help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgments, and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist MEA by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices".

My signature below indicates that I have been given the chance to review a current copy of MEA's "Notice of Privacy Practices".

_____ _____ _____

Patient or legally authorized individual signature Date Time

_____

Relationship to patient if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)

PATIENT CONSENT FORM

Patient Consent for Use/Disclosure of Health Care Information

Patient's name: _____ Date of birth: _____

SSN: _____ Previous name: _____

I understand that the patient's health information is private and confidential. I understand that Medical Eye Associates, PA, its subsidiaries and/or divisions, (hereafter referred to as MEA), works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that MEA may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. [*In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.]

MEA has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy. I understand that I have the right to read the "Notice" before signing this agreement.

MEA may update this "Notice of Privacy Practices". If I ask, MEA will provide me with the most current "Notice of Privacy Practices".

Under the terms of this consent, I can ask MEA to limit how the patient's personal health information is used or disclosed to carry out treatment, payment or health care operations. I understand that MEA does not have to agree to my request. If MEA does agree to my request, I understand that MEA would follow the agreed limits.

I may cancel this consent in writing at any time by doing one of the following:

I. Signing and dating a form that MEA can give me called "Revocation of Consent for Use and Disclosure of Health Care Information"; or

II. Writing, signing, and dating a letter to MEA. If I write a letter, it must say that I want to revoke my consent to authorize the use and disclosure of the patient's personal health information for treatment, payment, and health care operations.

If I revoke this consent, MEA does not have to provide any further health care services to the patient.

My signature below indicates that I have been given the chance to review a current copy of MEA's "Notice of Privacy Practices". My signatures means that I agree to allow MEA to use and disclose the patient's personal health information to carry out treatment, payment, and health care operations.

_____ _____ _____

Patient or legally authorized individual signature Date Time

_____

Relationship to patient if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)