

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 “HIPAA,” that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand Bergman Porretta Eye Center is not required to agree to my requested restrictions, but if you do agree then you are bonded to abide by such restrictions.

Patient Name (Print) \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

**CONSENT**

With this consent, Bergman Porretta Eye Center may call my home or other alternative location and leave a message on a voice mail or with the individual designated below in reference to any items that assist the practice in carrying treatment, payment, and healthcare operations.

With this consent, Bergman Porretta Eye Center may mail to my home or other alternative location any items that assist the practice in carrying out treatment, payment and healthcare operations.

The following individuals are designed to receive Protected Health Information on my behalf.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relation to patient

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relation to Patient