NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Full Notice of Privacy available upon request and posted on our webpage Bergmanporrettaeyecenter.com

I acknowledge that I have been given access to and made aware of my privacy rights.

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 except in circumstances where legally bound.

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 designated to receive Protected Health Information on my behalf.

_____________________________	_____________________________
Name	Relation to Patient
_____________________________	_____________________________
Name	Relation to Patient

I authorized the additional following forms of communication:

- ☐ *I consent to and accept the risk in receiving information via email. I understand I can withdraw my consent at any time.*
  My email address is ____.

- ☐ *I do not consent to receiving any information via email. I understand that I can change my mind and provide consent later.*