NTEC
North Texas Eye Center

Notice of Privacy Practice Acknowledgment
&
HIPAA Release Form

By signing this form, you will consent to our use and disclosure of your protected health information (PHI) for the following purposes:

- To conduct and plan treatment, including multiple healthcare providers who may be involved in treatment directly or indirectly.
- To obtain payment for services provided to you through third-party payers.
- To conduct normal healthcare operations such as quality assessments, etc.

I have received/been offered a copy of the above-named office's HIPAA Notice of Privacy Practice (NOPP) containing a detailed description of the use and disclosed of my PHI.

I understand that I have the right to revoke this consent at any time by giving us written notice of your revocation submitted to our office. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation.

I have had full opportunity to read and consider the contents of this consent form and this office's NOPP. I understand that, by signing this consent, I am giving my consent to your use and disclosure of my PHI to carry out treatment, payment activities, and health care operations.

Designated individuals Release Form

I, _____ (Patient or Guardian's full name) hereby acknowledge that I am giving consent to North Texas Eye Center for use and disclosure of my protected health information to carry out treatment, payment activities, appointment reminders and other health care operations. I have the right to revoke this consent any time by submitting a written declination letter.

You may also elect to have your PHI shared with your spouse, children or other parties outside the normal practice of North Texas Eye Care's healthcare operations. Please disclose below whom you may want to share your PHI info with.

1. **Spouse:** _____
2. **Child(ren)** _____
3. **Other:** _____
4. **Information is not to be released to anyone** ☐

Patient or Guardian signature Date

. . . . . .

OFFICE USE ONLY

_____ Patient or Guardian declined disclosure of Protected Health Information

Signature of HIPAA Privacy Officer Date

Patient Account Number: _____