



HIPAA ACKNOWLEDGEMENTS

Notice of Privacy Practices Acknowledgment

Our Notice of Privacy Practices (NPP) is available for review in person and on our website (newperspectiveeyecare.com/patient-center). A copy can be provided to you at any time.

By signing below I acknowledge that New Perspective Eye Care will share my personal health information with other parties to perform administrative duties, provide me with eye care services, and process my vision and health benefit claims. I **can be assured that this location does not sell my personal health information of any kind to a third party for such party's own use.** I authorize New Perspective Eye Care to submit my vision and medical insurance claims to receive reimbursement for the services and products I receive from New Perspective Eye Care.

Patient Name (PLEASE PRINT)

Date

Signature

Authorization Regarding Messages (optional)

I authorize leaving a detailed message on my home or cell number regarding medical treatment, care, test results, or financial information.

I authorize New Perspective Eye Care to release information to the following individuals: (optional)

1. _____ Relation: _____ may receive:

any information

only specific information: _____

2. _____ Relation: _____ may receive:

any information

only specific information: _____

3. _____ Relation: _____ may receive:

any information

only specific information: _____

4. _____ Relation: _____ may receive:

any information

only specific information: _____