

HIPAA PRIVACY

Acknowledgment of Receipt of Privacy Notice

By signing this acknowledgment of Receipt of Notice of Privacy Practices (the “Notice”); I acknowledge and agree that I have received a copy of the Notice of Privacy Practices for review and to keep for my records on the date identified below.

I understand that Eric Batiste OD may use and disclose necessary personal health information (for example, my name, address, subscriber identification number, eye exam information and/or type of products provided) to another party to permit Eric Batiste OD to perform its administrative duties, provide me with eye care services and products, process my vision benefit claims and communicate with me regarding vision care services provided by Eric Batiste OD (for example, mailings of exam reminders or information about services/products provided by Eric Batiste OD).

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 Eric Batiste OD to submit my vision benefit claims to my plan sponsor or health plan to receive reimbursement directly for the vision services and products that I have received from Eric Batiste OD.

Patient Signature or Patient’s Legal Representative

Date _____