RECEIPT OF "NOTICE OF PRIVACY PRACTICES"

I understand that Riverbend Eyecare will use and disclose **health information** about me, unless otherwise indicated below.

I understand that my **health information** may include information both created and received by Riverbend Eyecare, may be in the form of written or electronic records or spoken words and may include information about my health history, health status, test results, diagnoses, treatments, procedures, prescriptions and similar types of health-related information.

I understand and agree that Riverbend Eyecare may **use and disclose** my health information in order to:

- Make decisions about and plan for my care and treatment.
- Refer to, consult with. Coordinate among, and manage along with other health care providers for my care and treatment.
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how Riverbend Eyecare will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of Riverbend Eyecare and my rights regarding my health information.

I understand that the **Notice of Privacy Practices** may be revised from time to time, and that I am entitled to receive a copy of any revised **Notice of Privacy Practices**. I also understand that a copy or summary of the most current version of Riverbend Eyecare's **Notice of Privacy Practices** in effect will be posted in the waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed the manner described in the **Notice of Privacy Practices** and I understand that Riverbend Eyecare is not required by law to agree to such requests.

It is the policy of Riverbend Eyecare to release information to family members, friends and/or caregivers involved in your care, unless otherwise indicated.

____ I have objections to Riverbend Eyecare releasing information to the following: My objections are listed below.

Name ___________________________________
Name ___________________________________
Name ___________________________________

____ I have no objections to Riverbend Eyecare releasing information to family members, friends or caregivers involved in my care.

By signing below, I agree that I have reviewed and understand the information above And that I have received a copy of the Notice of Privacy Practices.

Patient's Name ____

Patient's Signature ____Date_________________

Patient's Representative signature______________________________________ Date________________

Description of Representative's authority:____

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