



Privacy Practices Acknowledgment and Consent Form

- I have received your Notice of Privacy Practices and/or I have been provided an opportunity to review it.
- I agree that telephone messages regarding my appointments, prescription renewals, lab results, and all other Protected Health Information* ("PHI"), may be left for me on voicemail systems and answering machines at the following telephone numbers, in addition to any other means of contact provided to you by me:

(____) _____ - _____ Home/Office/Cell/Email _____

(____) _____ - _____ Home/Office/Cell/Email _____

[If we need to contact you with Lab results, please place a check mark next to the preferred contact number, if any.]

I agree that my PHI may be shared with my spouse.

I agree that my PHI may be shared with the following other people:

Name	Phone Number	Date of Birth
_____	_____	_____

*as defined in the Health Insurance Portability and Accountability Act of 1996 and its regulations, ("HIPAA")

Patient Name (print): _____

Signature: _____ Date: _____

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and fill in the information below.

Parent/Guardian Name (print): _____ Relationship to Patient: _____

I understand that I can change any of the foregoing agreements, at any time, by giving written notice to Yuba Sutter Eye Care. My PHI may be further disclosed by such recipient for the purposes referenced above and that my PHI may no longer be protected by state and federal laws because I have authorized the release of such information. I also understand that if any harm results after the authorized release to such person(s), Yuba Sutter Eye Care will not be held liable for damages.

460 Plumas Blvd., Suite 102, Yuba City, CA 95991 (530) 743-7366 FAX: (530) 763-1170