ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the one-page NPP summary of key privacy rights, uses and disclosures from M. Hanif Peracha, M.D., P.C. (dba Eye Surgeons Associates) and understand that I may request a full copy of this privacy notice.

_____
Patient's Printed Name

_____ _____, 20_____
Signature of Patient (or Personal Representative*) Date of Signature

_____ _____
Personal Representative's Name (Printed) Relationship of Personal Representative

** The Personal Representative is the patient's decision maker if the patient cannot act for themselves. It can be the parent, legal guardian, health care surrogate, or other person.*

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

I wish to be contacted in the following manner (check all that apply):

☐ Home telephone ☐ May leave a detailed message ☐ Only leave message with a call back number

☐ Work telephone ☐ May leave a detailed message ☐ Only leave message with a call back number

☐ Cell phone ☐ May leave a detailed message ☐ Only leave message with a call back number

☐ Opt out of text messaging

☐ Email _____ ☐ Opt out of email messages

☐ May mail to my home address ☐ May mail to my work/office address

☐ May fax to this number_____ ☐ Other _____

Permission to Disclose

☐ **I permit the Practice to discuss and disclose my PHI to the following authorized individuals:**

☐ Spouse _____ ☐ Adult Child(ren)_____

☐ Parent(s)_ _____ ☐ Personal Representative_____

☐ Caretaker _____

_____
Patient's Printed Name

_____ _____, 20_____
Signature of Patient (or Personal Representative*) Date of Signature

_____ _____
Personal Representative's Name (Printed) Relationship of Personal Representative

** The Personal Representative is the patient's decision maker if the patient cannot act for themselves. It can be the parent, legal guardian, health care surrogate, or other person.*