North Texas Center for Sight
Acknowledgment of Review of the Notice
Of Privacy Practices
Patient Records of Disclosure

I have been given a copy or offered a copy of the Patient Rights and Patient Responsibilities of North Texas Center for Sight's, which explains how my medical information will be used and disclosed.

The HIPAA privacy rule gives individuals the right to request a restriction on notes and disclosure of their protected health information. The individual is also granted the right to request confidential communications, or that a communication be made by alternative means.

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

____ By my home telephone, my number is: _____
____ It is ok to leave me a message with detailed information
____ It is NOT ok to leave me a message with detailed information
____ It is ok to contact me at work and my number is: _____
____ It is ok to leave me a message at work with detailed information
____ It is NOT ok to leave me a message at work with detailed information
____ It is ok to leave a call back number only at my work

I authorize you to discuss my medical history and release any and all medical information to the following individuals: (Fill in all that apply)

____ My spouse, whose name is: _____ phone #: _____
____ My parent, whose name is:_____ phone #: _____
____ No one other than myself
____ Fill in any other name you desire: _____

Patient Signature: _____ Date: _____

Printed Name: _____ Date of Birth: _____

Name of legal guardian/ caretaker: _____