WORCESTER EYE CONSULTANTS P.C.

PATIENT ACKNOWLEDGEMENT OF HAVING READ OR BEEN READ THE NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

I have been provided the opportunity to read, or it has been read to me, the Notice of Health Information Privacy Practices at Worcester Eye Consultants.

I understand that Worcester Eye Consultants and its office staff are committed to treating and using protected health information about me responsibly.

I understand my rights as they relate to my records at Worcester Eye Consultants and understand how information about me may be used and disclosed.

I understand that my health record is the physical and legal property of Worcester Eye Consultants, but the information belongs to me. I may have access to inspect, amend or obtain a copy of my health information. Costs will incur for copies of my records, and appointments must be made with the Privacy Officer to inspect, access or amend my health information.

I understand that Worcester Eye Consultants is required to maintain the privacy of my health information. Worcester Eye Consultants will require my authorization to release my health information to outside sources with the exception of disclosures for purposes of treatment, payment and healthcare Operations. These may include: access to my health information by Worcester Eye Consultants and its office staff; billing to me or a third-party payer. In addition, business associates of Worcester Eye Consultants may from time to time, have access to my health information, but, I am assured that proper Business Associates Agreements are in place, ensuring the protection of my health information. Upon the physician's best judgment, Worcester Eye Consultants or it's office staff may disclose to a family member, relative or close personal friend or any other persons you identify, health information relevant to that person's involvement in my care. My health information may also be used for research data; funeral directors; organ procurement; marketing; FDA; public health or legal authorities; and/ or law enforcement purposes.

Worcester Eye Consultants may call me with appointment reminders, cancellations and may leave voice mail messages at my home or place of employment.

I have read and understand the Health Information Privacy Practices of Worcester Eye Consultants.

Patient (print name)_____ Date_____

Patient Signature_____

Presented to patient by_____