

Lisa K. DeMers, O.D.
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Hunter's Hill Eyecare Center

2811 N George St, Suite B
York, PA 17406
P: 717-848-2323
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www.huntershilleyecare.com

HIPAA PRIVACY FORM

Acknowledgment of Receipt

I (Name/DOB of patient): _____ acknowledge that I have received or been offered a copy of this organization's Notice of Privacy Practices, as required by the Health Insurance Portability and Accountability Act (HIPAA).

Authorization to Share Information (Optional)

I authorize this organization to disclose my protected health information to the following individuals:

Name: _____

Relationship: _____

Phone Number: _____

Name: _____

Relationship: _____

Phone Number: _____

Information to be shared (check all that apply):

- Medical records
- Billing information
- Appointment information
- Other: _____

I understand that I may revoke this authorization at any time in writing, except where action has already been taken in reliance on it.

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Patient Rights Statement

I understand that:

- My treatment, payment, enrollment, or eligibility for benefits is not conditioned on signing this authorization (unless allowed by law).
- I may refuse to sign this form.
- I have the right to revoke this authorization in writing at any time.

Patient Signature/Today's Date:

Print Name/Relationship if signing for another individual or a minor:
