CAROLINA EYECARE PHYSICIANS, LLC
Excellence in Ophthalmic Care
www.carolinaeyecare.com
John G.P. Boatwright, MD Paul M. Herring, MD Thomas J. Newland, MD Rober G. Reuther, MD Kerry D. Solomon, MD
R. Griffin Brame, MD H. Paul Cooler, MD Paul M. Grant, MD Jeffery K. Richards, MD Sidney M. Seltzer, MD Jeffrey F. Hood, OD

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

WHAT IS THIS NOTICE ABOUT AND WHY IS IT IMPORTANT?

This notice is required by the U. S. Department of Health and Human Services in order for me to be informed of how my health information will be used, disclosed, and protected, and about my rights regarding my health information. I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI).

I understand that this information can and will be used:

- **For Treatment:** We are permitted to use your health information or disclose it to others outside Carolina Eyecare Physicians, LLC in order to provide, plan and direct proper medical care for you.
- **For Payment:** We are permitted to disclose health information about your treatment and services in order to submit bills for the care and services you received, and collect payment from you, your insurance company or a third party payer.
- **For Health Care Operations:** We are permitted to use your health information to assess the care and the outcome in your case and others like it, in order to assure the highest quality of care for our patients.

When disclosing information, primarily appointment reminders and billing/collections efforts, we may leave messages on your answering machine/voice mail.

I understand your **Notice to Privacy Practices** containing a more complete description of the uses and disclosures of my PHI is available to me. I understand that this organization has the right to change its notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the **Notice of Privacy Practices.**

♦♦♦ I authorize / I DO NOT authorize Carolina Eyecare Physicians, LLC to release my protected health information to family members. ♦♦♦

(Please circle one)

Patient name: _____ DOB: _____

Signature (of Patient or Legal Guardian): _____

Date: _____

Practice Use Only

I attempted to obtain the signature of the patient or legal guardian in acceptance of the Notice Of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____

_____.