



HIPAA Notice

Patient Name: _____ Date: _____

To Comply with applicable HIPAA (Health Insurance Portability Accountability Act) regulations, we need you to complete the following information:

Please list any persons, other than your doctor, with whom we may discuss your private health information or financial matters.

Name: _____	Relationship: _____
Name: _____	Relationship: _____
Name: _____	Relationship: _____
Name: _____	Relationship: _____

If we are unable to reach you, do you give permission for us to leave a message:

On your answering machine/voice mail?

Yes: _____ No: _____

With someone at your home phone number?

Yes: _____ No: _____

Arkansas Eye Care Group in Maumelle has a "Notice of Privacy Practices" document that details how your private health information may be used. You are welcome to review the most current notice at your request.

Please sign below, stating that you have received and have reviewed this notice:

Patient's or Legal Guardian's Signature

Date

Relationship to Patient if Not Signed by Patient