Date: _____ Account #_____

OPHTHALMOLOGY ASSOCIATES

HIPAA and Acknowledgement of Receipt of Notice of Privacy Practices

Patient Acknowledgement – I have read the back of this form - "Patient Notice of Privacy Practices."

Pt. Name (Printed): _____**Date of Birth** _____

Address: _____Phone: _____

Patient Signature: _____

Patient's Preferred Language _____

Is the patient living or staying at a Skilled Nursing or Rehab Facility ? ☐ **Yes** ☐ **No**

If yes, Facility Name _____

Address:_____ **Phone:** _____

Name of Contact at Facility:_____

Name of Primary Care Physician:_____

IF YOU ARE COMPLETING THIS FORM FOR THE PATIENT

Your Name:_____

Relationship to patient:_____Phone# _____

Why is patient unable to complete this form? ☐ Pt. is blind ☐ Pt. has dementia

☐ Pt. is a child/minor - Are you the legal guardian or custodial parent? ☐ Yes ☐ No

If No, do you have a copy of Medical Power of Attorney or written permission from legal guardian to make medical decisions today? ☐ Yes ☐ No

Name of legal guardian _____ Phone _____

INFORMATION SHARING AUTHORIZATION Who can we discuss your medical information with including visits, treatments and diagnosis?

NAME	RELATIONSHIP	PHONE #

1._____

2._____

3._____

Is there anyone *who should NEVER be given* your medical information? If yes, please give name(s):

_____

CONTACT PREFERENCE – How may we contact you regarding appointments or medical information:

☐ Email Address: _____

☐ Cell Phone: # _____ May we leave a message? ☐ Yes ☐ No

☐ Home Number: # _____ May we leave a message? ☐Yes ☐ No

☐ Work Number: # _____ May we leave a message? ☐ Yes ☐ No

Ophthalmology Associates

Patient Notice of Privacy Practices

The protection of your health information is important to us at Ophthalmology Associates.

A comprehensive copy of our *Notice of Privacy Practices* is available:

- On our website at www.fw2020.com/patientinformation/patientforms, or
- At our front desk upon request.

Your healthcare services will not be affected by whether you sign this acknowledgement.

If you have any questions, please contact an Ophthalmology Associates physician or staff member.

Please Read the Following:

I acknowledge that I have had the opportunity to read the *Notice of Privacy Practices* at Ophthalmology Associates. I understand that:

- Ophthalmology Associates is committed to responsible use of my protected health information in compliance with state and federal laws, including HIPAA.
- My health record is the physical and legal property of Ophthalmology Associates, but the information belongs to me.
    - I may inspect, amend, or obtain a copy of my health information.
    - Costs may apply if I request a copy of my health information.
- Ophthalmology Associates will maintain the privacy of my health information.
    - Written authorization is required for disclosure to outside sources, except for treatment, payment, and healthcare operations.
    - I may revoke my authorization in writing at any time.

If I believe my privacy rights have been violated, I may submit a written complaint to:

Ophthalmology Associates
Attn: My Le, Privacy Officer
1201 Summit Avenue
Fort Worth, TX 76102

Notice Revision Date: June 2026