Twin Cities Eye
CONSULTANTS

Clinic Address:

Tel 612-999-2020

Street Address

City State Zip

Please print Patient name	Date of birth

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

- 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.
- I acknowledge that I have received your Notice of Privacy Practices. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.
- I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that you are not required to agree to my requested restrictions but, if you do agree then you are bound to abide by such restrictions.

X

Signature of patient or authorized party Date

X

Printed name of authorized party if not patient Relationship

MEDICAL & FINANCIAL DISCLOSURE

Dear Patient,

To protect your privacy and follow the new laws regarding patient privacy, we need your signature below on this form to disclose medical and/or financial information to any person other than yourself. If you do not sign this form below, we will not divulge any medical and/or financial information about you to anyone other than your insurance company.

Name	Relationship to you	Phone

X

Signature of patient Date

X

Signature of witness Date