NOTICE OF PRIVACY PRACTICES
ACKNOWLEDMENT AND CONSENT
Drummond Eye Clinic/Drummond Optical

The notice of Privacy Practices tells you how we may use and share your health records. **Please read it.**

- We will use and share your health records to treat you.
- We will use and share your health records to bill for the services we provide.
- We will use and share your health records to run our business.
- We will use and share your health records as required by law.

All the ways we may use and share your health records are explained in more detail in the Notice of Privacy Practices.

You have the following rights with respect to your health records.

1. You have the right to look at and receive a copy of your health records.
2. You have the right to receive a list of whom we have given your health records to.
3. You have the right to ask us to correct a mistake in your health records.
4. You have the right to ask that we not use or share your health records.
5. You have the right to ask us to change the way we contact you.

All of these rights are explained in more detail in the Notice of Privacy Practices.

I have received a copy of the Drummond Eye Clinic's Notice of Privacy Practices.

Signature:_____ Date:_____
(of Patient of Legal Representative)

Capacity of Legal Representative (if applicable): _____

I consent to the use and sharing of my health records for treatment, payment and operation purposes as described in the Notice of Privacy Practices. I know that if I do not consent, you cannot provide services to me.

Oklahoma law requires that we advise you that **the information authorized for disclosure may include information which may be considered a communicable or venereal disease, including, but not limited to, Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (AIDS).** It also may include mental health or other sensitive information.

Signature:_____ Date:_____
(of Patient of Legal Representative)

Capacity of Legal Representative (if applicable):_____
***May be requested to provide verification of representative status.**

Please list those individuals that you would like to give permission to access your **Protected Health Information (PHI):**

_____ Relationship to Patient:_____

_____ Relationship to Patient:_____

_____ Relationship to Patient:_____