Long Island Ophthalmic Care, P.L.L.C.

230 Hilton Ave, Suite 118
Hempstead, New York 11550
Tel: 516-481-1570 Fax: 516-481-1786

Acknowledgement of Receipt of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient's Rights section describing your rights under the law. You have the right to review our Notice before signing this acknowledgement. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or healthcare operations. I agree Long Island Ophthalmic Care, PLLC may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.

You have the right to revoke this consent, in writing, signed and dated by you. However, such a revocation shall not affect disclosures we have already made in reliance to your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I, ______________________________ (print name) give permission to this office to leave a message at the telephone numbers provided.

YES	NO	HOME NUMBER	
YES	NO	CELL NUMBER	
YES	NO	WORK NUMBER	
YES	NO	FAX TO OTHER DOCTORS	

Long Island Ophthalmic Care, P.L.L.C. may release any of my medical information to the following people (i.e. spouse, children, siblings, etc.):

Name ______________________ Relationship ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

Patient or Authorized Representative's Signature ______________________

Date ______________________