NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I understand that by signing this consent, I am acknowledging and have been informed of, as well as given the right to review and secure a copy of MOA's Notice of Privacy Practices. The notice contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA.

I understand that MOA may use and disclose my protected health information to carry out:

- Treatment (this includes all providers and other healthcare offices involved in my treatment plan)
- Obtaining payment from third-party payers (*e.g.*, my insurance company)
- The day-to-day healthcare operations of MOA

I understand that MOA reserves the right to change the terms of this notice from time to time and that I may contact MOA at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that MOA is not required to agree to these requested restrictions. However, if MOA does agree, then they are bound to comply with the restrictions.

_____ ____/____/____

Signature of Patient or Legally Authorized Representative Date — Date

_____ _____

Printed Name of Patient or Legally Authorized Representative — Relationship to Patient

OFFICE USE ONLY

I attempted to obtain the patient's signature on this Notice of Privacy Practices Acknowledgement, however, was unable to do so as document below:

Date:	Staff Member:	Reason:

PATIENT HIPAA COMMUNICATION FORM

Patient Name: _____ Date of Birth: _____

FAMILY & FRIENDS: It is the policy of MOA not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friends into the exam room, we will assume, unless you object, that the person is entitled to receive information regarding your treatment, (iv) in emergency situations, or (v) as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If you anticipate that you will need or want your medical information to be provided to family members, friends, or caregivers, please INDICATE THAT BELOW, so that we may best serve you. By signing below, you authorize the following persons to receive information, as requested, regarding your care and treatment. UPDATES to this form must be made in person.

Name	Relationship	Phone #
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALTERNATIVE COMMUNICATION: I wish to be contacted in the following manner (check all that apply):

Home Phone_____

_____ Okay to leave message with details

_____ Leave a call back number only

Cell Phone_____

_____ Okay to leave message with details

_____ Leave a call back number only

Work Telephone_____

_____ Okay to leave message with details

_____ Leave a call back number only

Written Communication

_____ Okay to mail to home address

_____ _____/_____/_____

Signature of Patient or Legally Authorized Representative Date — Date

_____ _____

Printed Name of Patient or Legally Authorized Representative — Relationship to Patient

MOA
MEDICAL OPTOMETRY AMERICA