BROWNSBURG
FAMILY EYE CARE, P.C.

Patient Name: _____

I authorize the following individuals access to my personal health information Brownsburg Family Eye Care.

Spouse: _____ Phone _____

Parent(s): _____ Phone _____

Parent(s): _____ Phone _____

Other: _____ Phone _____

Emergency Contact: _____ Phone _____

Signature _____ Date _____

HIPPA: NOTICE OF PRIVACY PRACTICES

Brownsburg Family Eye Care ("BFEC") is required by law to take reasonable steps to protect the privacy of your Protected Health Information ("PHI") and to provide you with notice of our legal duties and privacy practices with respect to PHI. PHI is information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. PHI includes prescription records maintained by us. The **Notice of Privacy Practices** ("Notice") describes how we may use and disclose PHI to carry out treatment, payment or health care operations and for our other specified purposes that are permitted or required by law. The Notice also describes your rights with respect to PHI about you.

I acknowledge that I have received / read a copy of the **Notice of Privacy Practices** for this office.

Signature _____ Date _____

I authorize **Brownsburg Family Eye Care** to provide vision services. I assign benefits payable by my insurance directly to BFEC, and understand ***I am financially responsible for any non-covered services***. I give permission for medical information to be released to my insurance company and its agents in order to process this claim for payment.

Signature _____ Date _____