Acknowledgement of Receipt of Notice of Privacy Practices

I, ______________________________________, hereby acknowledge that I received or was made aware of a copy of Envision Eye & Aesthetics Notice of Privacy Practices.

HIPAA Privacy Rules Designation of Personal Representative

I, hereby designate ____ (spouse, family member, friend) as my personal representative for purposes of all rights, obligations and responsibilities created under the HIPAA Privacy Rules.

I acknowledge and agree Envision Eye & Aesthetics (the "Practice") may disclose my protected health formation to my personal representative and that my personal representative has the authority to authorize the Practice to use and disclose my protected health information.

RELEASE OF INFORMATION

I assign all medical/surgical benefits to Envision Eye & Aesthetics for services performed by Envision Eye & Aesthetics. I authorize the release of information concerning my care to the health insurance agency listed above.

I understand and agree that, regardless of the insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. Furthermore, I understand that if my account is turned over for collection that I will be responsible for all fees and expenses incurred by any collection agency or attorney.

Patient Signature or Representative ____

Name of Representative ____________________________________ Date ______________________