Notice of Privacy Practices Receipt

Our Notice of Privacy Practices (NPP) provides information on how our practice may use and/or disclose protected health information about you for treatment, payment and health care operations. A copy of our NPP can be found at the check-in desk or at www.westminstervision.com.

Patient's Name (Print): _____

Patient's Date of Birth: _____

I authorize the following person(s) to have access to my health information:

Name/Relationship to Patient: _____

Name/Relationship to Patient: _____

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in the document by sending a written notification to Westminster Vision Associates. Also, I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned upon signing. This information shall be in effect until revoked by me.

Signature of Patient: _____ Date: _____

_____ _____

Signature of Patient Representative Date

(Required if Patient is a minor or an adult who is unable to sign this form)

_____

Print Name

_____

Relationship of Patient Representative to Patient