

# Ophthalmology NJ, LLC

## Receipt of Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice and ask questions regarding our privacy practices. As provided in our notice, the terms of our notice may change. The privacy notice is posted in each of our location waiting rooms. You may request a copy of the notice or any revised notices from our reception staff. You have the right to request that we restrict how protected information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement. By signing this form, you acknowledge that you have received our Notice of Privacy Practices.

\_\_\_\_\_  
Name of Patient

\_\_\_\_\_ If Patient is a minor

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Authorized Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authorized Signature

### Permission to Discuss Healthcare Information

I authorize the Physicians and staff of the Eye Institute of Essex to discuss my healthcare and treatment with the following listed family members or significant others:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Date: \_\_\_\_\_

<b>FOR OFFICE USE ONLY</b>
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#### INABILITY TO OBTAIN ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

To be completed only if no signature is obtained. If it is not possible to obtain, the individual's acknowledgment, describe the good faith efforts made to obtain the individual's acknowledgment, and the reason why the acknowledgment was not obtained.

Reason: \_\_\_\_\_

Signature of Staff Member: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_