Rebecca Sparks, OD
Sparks Eye Care LLC
307 W Highway 54, Ste 100
Andover, KS 67002
316-201-1837

Acknowledgment of Receipt of Notice of Privacy Practices
HIPAA Consent Form

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).

By signing this consent, I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (i.e. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA.

_____

Signature of Patient or Patient's Representative/Guardian Date

_____

Print Name Relationship to Patient

Sparks Eye Care LLC

PERMISSION TO DISCLOSE MEDICAL INFORMATION PATIENT

PATIENT NAME	BIRTH DATE	ADDRESS

1. I authorize Sparks Eye Care LLC to discuss or release health information identifying me to the following individuals/entities:

_____ _____
NAME RELATIONSHIP TO PATIENT

_____ _____
NAME RELATIONSHIP TO PATIENT

_____ _____
NAME RELATIONSHIP TO PATIENT

2. This authorization to disclose MEDICAL AND FINANCIAL information is being made voluntarily and at my request.

3. In signing this authorization, I understand and acknowledge the following
(Initial in the space provided):

_____ I understand that this authorization is voluntary and that I may refuse to sign it.

_____ I understand that my refusal to sign this authorization will not affect my ability to obtain treatment, receive payment or eligibility for benefits unless allowed by law.

_____ I understand that I may revoke this authorization at any time by notifying Sparks Eye Care in writing of my intent to do so, except to the extent that action has been taken in reliance on this authorization.

_____ I understand that, unless other date specified, this authorization will never expire.
___/____/____

_____ I understand that once the disclosures authorized herein have been made, the information disclosed may be subject to re-disclosure by any recipient, and no longer protected by federal privacy law.

I affirm I have read and understand the above information.

_____ _____
Date Signature of Patient/Legal Representative

_____ _____
Printed Name of Legal Representative Description of Relationship to Member