Mason Family Eye Care

109 E. Maple Street
Mason, MI 48854
517-676-4499

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_________________________________ Date_______________
Print Patient's Name

The undersigned does hereby acknowledge that he or she has been offered a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

By_________________________________ Date _______________
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_________________________________
Signature of Parent/Guardian (circle one)

Persons who have permission to access my medical information or pick up materials on my behalf:

Name	Phone	Relationship