



Robert R. Szeliga, O.D.
Virgilio Gozum, O.D.
Kathryn Beckman, O.D.
5238 Main Street
Spring Hill, TN 37174

ACKNOWLEDGEMENT OF PRIVACY POLICY AND PRACTICES

I understand that in an attempt to protect the privacy of my identifiable health information, Spring Hill Eyecare, PLLC has established a **Privacy Policy** and guidelines for **Privacy Practices** within their office. This information details the use and/or disclosure of information contained in my personal medical/optometric records kept for the purpose of diagnosis, treatment, payment and health care operations. In accordance with HIPAA Regulations, a copy of the **Notice of Privacy Practices** of Spring Hill Eyecare, PLLC has been made available to me while in the office today. Should I choose to have a personal copy, one will be given to me at no charge.

- I have read, understand, and acknowledge the **Notice of Privacy Practices** of Spring Hill Eyecare, PLLC.
- I have elected not to read the **Notice of Privacy Practices** of Spring Hill Eyecare, PLLC, but have been given the option to have a personal copy today.

I understand that the Practice may wish to contact me for purposes related to my treatment such as to remind me of appointments, leave messages, or to discuss financial/billing business, or to indicate other necessary contacts.

Patient name: _____

Signature (or patient's representative): _____ Date: _____

Please Initial

- Yes, I authorize the Practice to contact me at the phone #s/email I have provided. I understand and authorize the practice to leave a voicemail message if I am unavailable.
- No, I do not agree to be contacted. Do not leave a message.

The following people may have access to my personal health information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____