PATIENT ACKNOWLEDGEMENT
OF HAVING READ OR BEEN READ THE
NOTICE OF HEALTH INFORMATION PRACTICES OF
EYE CLINICS OF SOUTH TEXAS P.A.

I have been provided the opportunity to read, or it has been read to me, the Notice of Health Information Practices at EYE CLINICS OF SOUTH TEXAS P.A., JAY M. RUBIN, M. D.

I understand that EYE CLINICS OF SOUTH TEXAS P.A. is committed to treating and using protected health information about me responsibly.

I understand my rights as it relates to my records at EYE CLINICS OF SOUTH TEXAS P.A. and understand how information about me may be used and disclosed.

I understand that my health record is the physical and legal property of EYE CLINICS OF SOUTH TEXAS P.A., but the information belongs to me. I may have access to inspect, amend or obtain a copy of my health information. Costs will incur for copies of my records, and appointments must be made with the Privacy Officer to inspect, access or amend my health information.

I understand that EYE CLINICS OF SOUTH TEXAS P.A. is required to maintain the privacy of my health information. EYE CLINICS OF SOUTH TEXAS P.A. will require my authorization to release my health information to outside sources with the exception of disclosures for purposes of Treatment, Payment and Healthcare Operations. These may include: access to my health information by EYE CLINICS OF SOUTH TEXAS P.A. staff and physicians; billing to myself or a third-party payer; in addition, business associates of EYE CLINICS OF SOUTH TEXAS P.A., may from time to time, have access to my health information, but, I am assured that proper Business Associates Agreements are in place, insuring the protection of my health information; upon the physicians best judgment, we may disclose to a family member, relative or close personal friend or any other persons you identify, health information relevant to that person's involvement in my care; may be used for research data; funeral directors; organ procurement; marketing; FDA; public health or legal authorities-, and/ or law enforcement purposes.

EYE CLINICS OF SOUTH TEXAS P.A. may call me with appointment reminders, cancellations and may leave voice mail messages at my home or place of employment.

I have read and understand the Health Information Practices of EYE CLINICS OF SOUTH TEXAS P.A..

Patient Signature: _____ Date :_____

Witness : _____ Date : _____