HIPAA PRIVACY
ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

By signing this acknowledgment of Receipt of Notice or Privacy Practices (the "Notice"); I acknowledge and agree that I have received a copy of the Notice or Privacy Practices for review and to keep for my records on the date identified below.

I understand that the location may use and disclose necessary personal health information (for example, my name, address, subscriber identification number, eye exam information and/or type of products provided) to another party to permit the location to perform its administrative duties, provide me with eye care services and products, process my vision benefit claims and communicate with me regarding vision care services provided by the location (for example, mailings of exam reminders or information about services / products provided by the location).

I can be assured that this location does not sell my personal health information of any kind to a third party for such party's own use. I acknowledge and agree that the location may submit my vision benefit claims to my plan sponsor or health plan to receive reimbursement directly for the vision services and products that I have received form the location.

AUTHORIZATION FOR THE USE AND DISLCLOSURE OF INDIVIDUALLY INDENTIFIABLE HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

1. Persons/organizations authorized to use or disclose the information: Office of Dr. Michelle Xiao-ou Ren (Practice Name), to receive the information: Watchung Eye Care LLC
2. Specific description of information that may be used/disclosed: **my name, address, telephone number, email address and next appointment date(s) and time(s)**
3. **As part of our recall program, the information will be used/disclosed for the following purposes**:
    a) for the purpose of providing coupons and service and product information and
    b) To compare mailing lists with Watchung Eye Care LLC to help avoid duplicate mailings.
4. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment or eligibility for benefits unless allowed by law.
5. The organization authorized to use/disclose the information will receive compensation for doing so. YES. __NO X
6. I understand that I may inspect or copy the information used or disclosed.
7. I understand that I may revoke this authorization at any time by notifying the person/organization providing the information in writing, except to the extent that:
    a) Action has been taken in reliance on this authorization; or
    b) If this authorization is obtained as condition for obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

This authorization expires four years form the date of my signature.

_____ _____
Signature of patient or patient's representative Date

_____ _____
Printed Name of Patient or Patient's Representative Relationship to patient or representative's authority to act for the patient

I hereby authorize the payment of medical benefits to Dr. Xiao-ou Ren for services rendered. I understand that I am financially responsible for any services not covered by my insurance carrier.

I further agree to pay all collections costs. Attorney fees, and other collections costs that may be incurred to enforce the collection of any amounts outstanding.

I hereby authorize my insurance to release any medical information necessary to complete and process my insurance claims.

PATIENT OR INSURED SIGNATURE: _____Date_____
(if patient is a Minor, must have Responsible Party Signature)

I authorize Dr. Xiao-ou Ren to treat me and use my personal health information for healthcare operations

PATIENT OR INSURED SIGNATURE: _____Date_____
(if patient is a Minor, must have Responsible Party Signature)