ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

This acknowledgement of notice and consent authorizes Capital Vision Center, Inc. to use and disclose protected health information about you for treatment, payment and health care operation purposes.

NOTICE OF PRIVACY PRACTICES:

Capital Vision Center's Notice of Privacy Practices describes how we may use and disclose your PHI and how you can access your PHI and exercise other rights concerning your PHI. You may review our current notice dated April 14, 2003 prior to signing this acknowledgement and consent.

Amendments: We, Capital Vision Center, Inc. reserve the right to change our Notice of Privacy Practices dated April 14, 2003 and to make the terms of any change effective for all Protected Health Information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our office.

Acknowledgement and Consent

I have read and understood the Notice of Privacy Practices dated April 14, 2003 for Capital Vision Center, Inc. Capital Vision Center, Inc. is authorized to use and disclose protected health information about _____ for treatment, payment and healthcare operation purposes consistent with its Notice of Privacy Practices dated April 14, 2003.

Authorization to Use and/or Disclose Health Information

This authorization gives Capital Vision Center, Inc. permission to use and/or disclose protected health information about you.

Right Not To Sign: You may refuse to sign this authorization. Refusal to sign this authorization will not affect your ability to obtain treatment by Capital Vision Center, Inc., except in the case of health care that is solely for the purpose of creating health care information for disclosure to a third party.

Right to Revoke: You may revoke this authorization at any time. To revoke this authorization, you must submit a written revocation to our office at the following address:

Capital Vision Center, Inc.

dba Drs. Smith & Saracino

4854 Londonderry Rd, Harrisburg

3100 Gettysburg Rd, Camp Hill

_____

(Name of Patient)

X_____

(Signature of Patient or Patient's Personal Representative)

_____

(Date)

Patient Authorization On How To Disclose Information

In general, the HIPAA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of Private Health Information (PHI). The individual is also provided the right to request confidential communications of PHI is made by alternative means, such as sending correspondence to the individual's office instead of home.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER:

Home Telephone _____

Leave message with detailed information

Leave message with call back number only

Work Telephone

_____

Leave message with detailed information

Leave message with call back number only

Written Communication

Mail to my home address

Mail to my work/office address

Fax to this number _____

Other specific directions for disclosing information:

_____

_____