**HIPAA Consent**  
**NEW JERSEY EYE CENTER**  
**Acknowledgment of Privacy Practice Notice and Designation of Disclosure**

1. Acknowledgment of Privacy Practice Notice

I have received a copy of the New Jersey Eye Center Notice of Privacy Practices.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_**

*Patient’s Name                           DOB             Signature of Patient/Parent/Guardian                     Date*

1. Designation of Certain Relatives, Close Friend and Other Caregivers

**[ ]** Initial                     **[ ]** Update

I agree that the New Jersey Eye Center may disclose certain portions of my health information to a family member, close friend and Other Caregiver because such person is involved with my health care or payment relating to my health care. In that case, New Jersey Eye Center will disclose only information that is directly relevant to the person’s involvement with my health care or payment relating to my health care.

**[ ]** I wish to make no designation at this time.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_        \_\_\_\_\_\_\_\_\_\_\_\_

*Signature of Patient/Parent/Guardian                             Date*

I designate the following persons listed below as persons involved with my health care or payment relating to my health care for the purpose of New Jersey Eye Center making the limited disclosures described above. (I understand that I am not required to list anyone. I also understand that I may change this list at any time in writing.)

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last 4 digits of his/her SS#(required):\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last 4 digits of his/her SS#(required):\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last 4 digits of his/her SS#(required):\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last 4 digits of his/her SS#(required):\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last 4 digits of his/her SS#(required):\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last 4 digits of his/her SS#(required):\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last 4 digits of his/her SS#(required):\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last 4 digits of his/her SS#(required):\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_                         \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Signature of Patient/Parent/Guardian                                                                  Date*