Health Insurance Portability Accountability Act (HIPPA)

Our practice is dedicated to maintaining the privacy of your individual protected health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentially of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By signing this you acknowledge that we have offered you a copy of our privacy policy.

Signed_____Date_____

Permission to Communicate Form

So that Dr. Mauney Optometry, P.A. May serve you better, you have the option of providing us with a list of people with whom we may discuss the patient's appointments, referrals, test and lab results, and other health/financial information.

I, _____, give permission for Dr. Christopher K. Mauney Optometry, P.A. To share health/financial information with the below named.

Name of person	Relationship

___ I DO NOT WISH TO GIVE ANYONE PERMISSION TO COMMUNICATE.

Signature_____Date_____

Printed name of patient_____

Witness Signature_____ Date_____

This form expires 3 years from the date of the patient's signature and must be renewed at that time.