Birch Run Eyecare Associates

8470 Main Street
Birch Run, MI 48415
(989) 624-2020

Patient Acknowledgement and receipt of
Notice of Privacy Practices Pursuant to HIPAA and Consent of Use of Health Information

Name_____ Date_____
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State Law and Federal Law.

Patient's Signature_____Date_____

If patient is a minor or under guardianship order as defined by State Law:

Signature of Parent/Guardian (circle one) _____Date_____

Persons who have permission to access my medical information or pick up materials on my behalf:

Name	Phone	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____