ACKNOWLEDGEMENT AND CONSENT:

I understand that Wayne L. Gerig O.D./20/20 Eye Care Professionals (here aforementioned as, "This Practice") will use/disclose health information about me. I understand that this information may include; health history, health status, symptoms, examinations, test results diagnoses, treatments, procedures, prescriptions, and similar types of health-related information. This information may be created by the practice, received through written or electronic records and/or through spoken words. I understand and agree that This Practice may use and disclose my health information in order to:

1.) Make decisions about and plan for my care and treatment

2.) Manage patient care more efficiently through referral, consultation, coordination and shared information with other appropriate health care providers.

3.) Determine my eligibility for health plan or insurance coverage. To submit bills, claims and other pertinent information to insurance companies and others responsible to pay for some or all of my health care.

4.) Perform various office administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for, quality cost effective health care. I understand that I have the right to receive and review a written description of how this practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** which describes the uses and disclosures of health information made and information practices followed by the employees, staff and other office personnel of This Practice. It also, informs me of my rights regarding my health information. I understand that the Notice of Privacy Practices may be revised periodically and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect, is posted in waiting /reception area. I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

By_____ Date_____

(Patient)

By_____ Date_____

(Patient Representative)

Description of Representative's Authority_____