Janet Corbit-Drakulich, O.D., M.Ed. • 2874 N. Carson St., Suite 210 • Carson City, NV 89706 • 775.887.8866 • Fax 775.461.0299

Patient Name: ______________________________ Date of Birth: ____________________

NOTICE OF RETENTION

This notice is to advise you that your medical records will be retained for a period of 5 years. If you are under the age of 18 at the time of the first visit, then the records will be kept for a period of 5 years starting with the first date of treatment following your 18th birthday. For current patients, the 5 year retention period begins on the date of the last treatment by the doctor or 5 years from the date you become 18 years of age.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

· Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

· Obtain payment from third-party payers (i.e. your insurance company).

· Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Statements* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

HIPAA FAMILY MEMBER INFORMATION

You have the right to restrict family members or other persons from accessing your health information. However, you may wish to allow your spouse, family member or another person to have access to your health information. Please list any family member or other person, doctor or medical facility that you wish to authorize access to your medical &/or payment information.

Name: ______________________________ Relationship: ______________ Phone: ________________

Name: ______________________________ Relationship: ______________ Phone: ________________

Name: ______________________________ Relationship: ______________ Phone: ________________

Signature: ______________________________________ Date: __________

Name & Relationship to Patient (print): ______________________________________

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason: