# NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

## DR. JAMES W. SHAVER

## OPTOMETRIST

## 301 S. MAIN ST., LANDIS, NC 28088

OUR NOTICE OF PRIVACY PRACTICES PROVIDES INFORMATION ABOUT HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU. YOU HAVE THE RIGHT TO REVIEW THE COMPLETE NOTICE BEFORE SIGNING THIS CONSENT. IF WE CHANGE OUR NOTICE, YOU MAY OBTAIN A REVISED COPY BY CONTACTING OUR OFFICE AT 704-857-2238.

YOU HAVE THE RIGHT TO REQUEST THAT WE RESTRICT HOW PROTECTED HEALTH INFORMATION ABOUT YOU IS USED OR DISCLOSED FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS. WE ARE NOT REQUIRED TO AGREE TO THIS RESTRICTION, BUT IF WE DO, WE ARE BOUND BY OUR AGREEMENT.

YOU HAVE THE RIGHT TO REQUEST THAT WE NOT SHARE INFORMATION ABOUT YOUR TREATMENT TO YOUR HEALTH PLAN IF YOU PAY CASH IN FULL AND YOUR HEALTH PLAN IS NOT BILLED FOR ANY SERVICES.

YOU HAVE THE RIGHT TO REQUEST A COPY OF YOUR ELECTRONIC MEDICAL RECORD.

YOU HAVE THE RIGHT TO REQUEST THAT YOU BE EXCLUDED FROM ANY MARKETING BY THIS OFFICE.

YOU HAVE THE RIGHT TO RESTRICT THE USES AND DISCLOSURES OF YOUR INFORMATION. IF YOU BELIEVE YOUR PRIVACY HAS BEEN COMPROMISED BY THIS OFFICE, PLEASE EXPRESS YOUR CONCERN TO US IN WRITING.

OTHER THAN THE PROCEDURES STATED ABOVE OR WHERE REQUIRED BY FEDERAL, STATE OR LOCAL LAW, WE WILL NOT DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN AUTHORIZATION. YOU MAY REVOKE THAT AUTHORIZATION AT ANY TIME.

☐ BY CHECKING THE BOX, I AM GIVING MY PERMISSION TO RECEIVE TEXT MESSAGING FROM DR. JAMES W. SHAVER. I UNDERSTAND THAT THERE COULD BE CHARGES FOR TEXT MESSAGES FROM MY MOBILE CARRIER. I UNDERSTAND THAT I CAN REVOKE THIS AGREEMENT IN WRITING AT ANY TIME.

PATIENT NAME (PRINT): _____

PATIENT SIGNATURE: _____ DATE: _____