**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES**

The law requires that Michael F. Ringel, O.D., Inc. make every effort to inform you of your rights related to your personal health information. By signing below, you acknowledge that:

* I have read or had explained to me prior to any services offered, Michael F. Ringel, O.D., Inc.’s Notice of Privacy Practice, and agree to continue my care under said terms.
* I was given the opportunity to read Michael F. Ringel, O.D., Inc’s Notice of Privacy Practices and declined but wish to continue my care under the terms of the Practice’s privacy policies.

**PATIENT AUTHORIZATION FOR PERSONAL REPRESENTATIVE**

I authorize the practice to disclose or provide my protected health information to the following individual who is authorized to act as my personal representative for the purposes of receiving all protected health information about myself. As my designated personal representative, he/she may exercise my right to inspect, copy, and request amendments to my protected health information. He/she may also consent or authorize the use of my protected health information. However, we will not have any control over how your representative discloses your protected health information to others.

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Representative Relationship to Patient

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Phone

You have the right to revoke or terminate this authorization by submitting a written request to our Privacy Officer, Dr. Michael Ringel.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

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Patient Date of Birth Date