Eric B. Sputh, M.D.
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Michelle Langkawel, O.D.

Acknowledgment of Privacy Practices and Consent for Disclosure of Protected Health Information

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Patient Name **Date of birth**

In the course of providing ophthalmology services to you, our practice creates, receives, and stores health information that identifies you. It is often necessary to use and disclose this protected information while providing treatment, seeking payment, and conducting healthcare operations. By signing below, you acknowledge that you have been given the opportunity to review and/or request a copy of our Notice of Privacy Practices on the date indicated, as required by federal law. A copy of our Privacy Practices is posted for review in the main waiting area near the check-in counter. You may also request a copy for your records from any employee at any time. A copy is also available in large print. If you have any questions regarding North River Ophthalmology's Notice of Privacy Practices, please ask to speak with our Privacy Officer, as indicated on the Privacy Notice.
North River Ophthalmology is allowed to release and communicate with the individuals listed below regarding my protected health information as of this date or until cancelled:

Spouse ______________________________ **Phone Number** ______________

Children ______________________________ **Phone Number** ______________

Parents ______________________________ **Phone Number** ______________

Other Parties ______________________________ **Phone Number** ______________

______________________________ ______________

Signature of Patient or Parent/Guardian **Date**

As a personal representative, I have authority to act for the individual because I am the:

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