Kathryn Najafi-Tagol, MD
4000 Civic Center Dr, Ste 200A
San Rafael, CA 94903
(415) 444-0300

PRIVACY ACKNOWLEDGEMENT AND GENERAL CONSENT

I understand my privacy is protected and I have read the Notice of Privacy Practices.		☐ Yes
I consent to receive medical care and treatment from Eye Institute of Marin.		☐ Yes
I have read and understand the Office and Financial Policies. I understand any violation of these terms is subject to referral to a collection agency and/or immediate dismissal.		☐ Yes
I give my physician and/or my physician representative permission to leave a confidential message for me at the following phone number:		☐ Yes
I give my physician and/or my physician representative permission to discuss by medical care with:	Name/Relationship:	Phone:

I understand under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain right to privacy regarding my protected health information. I understand 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 or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge I have read/received your Notice of Privacy Practices containing a more complete desprition of the uses and disclosures of my health information. I understand this organization has the right to change its Notice of Privacy Practices from time to time and I may contact this organization at any time in writing to obtain a current copy of the Notice of Privacy Practices.

I understand 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.

____

Patient Name (Print) Date

____

Patient/Guardian Signature Relationship to Patient (if applicable) Date of Birth

For office use only:
I attempted to obtain the patient’s signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:________________________ Signature:_______________________________________

Reason:____