RESTON EYE ASSOCIATES, PLLC
ELLE MILANI, MD

1800 TOWN CENTER DRIVE SUITE #316
RESTON, VA 20190
(703) 787-4700

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of the office's Notice of Privacy Practices.
Patient Name

PATIENT RECORD OF DISCLOSURES

In general the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

Home phone
____ permission to leave detailed message
____ leave message with call back number only

Cell phone
____ permission to leave detailed message
____ leave message with call back number only

Work phone
____ permission to leave detailed message
____ leave message with call back number only

Written Communication may be sent to:
____ my home address (on file)
____ my work address: _____
____ fax #_____

If you have someone you would like us to communicate with regarding your medical care, please write their name in the space provided below. If you do not note this person, we will be unable to discuss any patient/medical issues with them.

_____
_____
_____

_____ _____
Patient Signature Date