Gupta Eye Center LLC
310 S County Farm Rd.
Suite B
Wheaton, IL 60187

Privacy Practices

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of the HIPAA requirements, Gupta Eye Center LLC is providing you with a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices. Existing Illinois law requires us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim challenging our professional competence; a review of the entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse / neglect investigation.

In some instances, it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another covered entity for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Patient Acknowledgment, Consent, & Authorization

Please sign this form below to acknowledge that you have received our Notice of Privacy Practices. A copy of our Privacy Practices is available at the front desk.

Please sign this form below to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.

I acknowledge that today I have received a copy of the Notice of Privacy Practices. I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. This includes communication with laboratories or other specialists for any medical treatment, consultations, educational purposes, or for any other purpose deemed appropriate by Gupta Eye Center LLC.

_____	_____
Patient Signature	Parent/Guardian/Representative Signature
_____	_____
Patient Name (Please Print)	Parent/Guardian/Representative Name
_____	_____
Patient Date of Birth	Relationship to Patient
_____	
Date	

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For Office Use Only

Patient Declined to Sign

The following circumstances prohibited the patient from signing the Acknowledgement/Consent.

_____
_____
_____
_____

_____
Office Personnel Signature

_____
Office Personnel Name (Please Print)

_____
Date