MISSISSIPPI EYE ASSOCIATES

James D. Sutton, M.D. Debra LaPrad, M.D.
CATARACT & LENS IMPLANT **COMPREHENSIVE OPHTHALMOLOGIST**

PERMISSION OF CONTACT / HIPPA ACKNOWLEDGEMENT FORM

Date: ____/_____/_____

I, _____, give Mississippi Eye Associates, doctors and staff permission to contact me by phone or mail regarding appointment reminders, billing questions, test results, and information need to process insurance claims.

I also give Mississippi Eye Associates permission to contact me about payment on my bill.

I give Mississippi Eye Associates permission to talk to the following persons regarding my account.

_____ _____
Name **Phone Number**

_____ _____
Name **Phone Number**

FORM OF ACKNOWLEDGMENT..... HIPPA ACT OF 1996

By signing this form you are acknowledging that we have advised you of the Privacy Act as required by law. Mississippi Eye Associates adhere to the rules of the HIPPA ACT adopted to law in 1996.

_____ _____
Patient's Signature or Authorized Individual Witness