FAMILY EYE CENTER

for the life of your eyes

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT
HIPAA COMPLIANCE PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that 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 involed in that treatment directly and indirectly.

* Obtain payment from third party payers

* Conduct normal healthcare operations, such as quality assessment and physician certifications..

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the Notice may change also. A summary of the Notice will be posted in our office and on our website (www.familyeye2020.com) indicating the effective date of the Notice. We will offer you a copy of the Notice on your first visit to us after the effective date of the then current Notice.

As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. **We are not required to agree to your request.** If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment.

I hereby authorize the following people to be verbally made aware of my test results, appointment times, patient account status, and medical information:

NAME:_____Relationship:_____
NAME:_____Relationship:_____
NAME:_____Relationship:_____

Can messages (i.e.appointment reminders) be left at your home YES ____ NO _____
Where do you prefer to receive messages? _____

I understand that if someone inquires about any of the information listed above and is NOT listed on this consent form, information will NOT be released. I also understand that an authorization of release MUST be signed for the nonverbal release of any medical records.

_____
Printed Name of Patient DOB

_____OR
Signature of Patient Date

_____
Printed Name of Authorized Representative

_____
Signature of Authorized Representative Date