

## **(HIPAA) Notice of Privacy Use and Patient Consent Form**

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare Operations. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive. By signing this form, I understand that:

- Protected health information may be disclosed for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The patient has the right to revoke consent in writing at any time and all full disclosures will cease.
- The practice may condition receipt of treatment upon execution of this consent.
- The allowing of using information for calling in pharmacy or optical prescriptions.
- The allowing of use of information for referring you to another doctor or clinic.

Your signature on this form gives us your consent to call out your name in our office in order to escort you to the exam rooms, dispense your glasses, etc.

The HIPAA law also gives you rights regarding your health information. You can request:

- Copies of your health information will have a 30-day response time, we can charge for this service
- To review your records in writing, which we will respond within 30 days.
- Amendments to your records must have a written request which we will respond within 30 days.

Your signature on this form will give us the right to phone, email, or send a text to you to confirm appointments. We may leave a message on your answering machine at home or on your cell phone. We may discuss your medical condition with any member of your family.

A more complete description of your rights and our notice of privacy practices are available by the reception desk in our office. My signature below verifies that I have read and agreed to the conditions of this consent form.

This consent was signed by: \_\_\_\_\_  
(PRINT NAME PLEASE)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_