The Eye Clinic Inc. Notice of Privacy Practices and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text will be presented to you upon request and is posted in our offices.

This notice describes how we, The Eye Clinic, Inc., use or disclose your Protected Health Information ("PHI"). PHI is information that identifies you and relates to health care services, the payment of health care services or your physical health or condition, in the past, present or future. This notice also describes your rights to access and control your PHI.

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of PHI information with other healthcare providers for treatment, with health insurance payers who provide payment and for healthcare operations.
2. We are required to notify affected individuals following a breach of unsecured PHI.
3. We will not use or disclose your PHI without authorization, except described in our privacy notice.
4. We may change, add, delete or modify any of these provisions to better serve the needs of the practice and the patient.
5. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
6. Your confidential information will not be sold to a business associate or any other third party without obtaining proper authorization.
7. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
8. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
9. You agree to bring any concerns or complaints regarding privacy to the attention of The Eye Clinic, Inc. privacy officer.
10. We agree to provide patients with access to their records in accordance with state and federal laws.
11. You have the right to a Personal Representative. You may identify persons to us who may serve as your authorized personal representative.
12. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.
13. You have a right to inspect and copy your PHI upon request.
14. You have the right to request that we amend your records, if you believe that your PHI is incorrect or incomplete.
15. You may request an accounting of disclosures of your PHI made by us.

I hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

_____ **Date:** _____

(SIGNATURE)

_____

(PRINT NAME)

This notice is effective April 1, 2013

The Eye Clinic Inc.

Authorization for sharing Protected Health Information (PHI)

Due to HIPAA laws, we are not permitted to speak with anyone in regards to your care unless they are listed by our patient.

Please **PRINT** the name person(s) that you will allow us to speak to in regards to your personal medical information.

Name:

Relationship:

Contact #

Name:

Relationship:

Contact #

Name:

Relationship:

Contact #

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization shall be in effect until revoked by the patient.

_____ _____

Signature of Patient or Personal Representative Date

_____

Printed name of Patient or Personal Representative

_____

Description of Personal Representative's Authority (attach necessary documentation)