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HIPAA Patient Consent Form

Precision Eye Care provides this Consent to comply with the Privacy Regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

We understand that your medical information is personal to you and we are committed to protecting such information. As our patient, we create medical records about your health, our care for you and the services and/or items we provide you. By law, we are required to make sure that your protected health information is kept private.

This is a summary of and consent for the privacy practices and patient care at Precision Eye Care and services as a condensed version of our Notice of Privacy Practices. You have the right to review our Notice before signing this Consent. The terms of our Notice may change and you may obtain a revised copy by contacting our office.

If you ever believe your privacy rights have been violated, you may file a complaint with the Compliance Officer of Precision Eye Care or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing complaints.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

How will we use or disclose your information? Here are a few examples:

- For vision, medical eye treatment & referral
- In emergency situations
- To prevent serious threats to health safety
- To obtain payment & file insurance
- For appointment and patient recall reminders
- In response to certain requests arising out of lawsuits or other disputes

You have certain rights regarding the information we maintain about you. These rights include: the right to inspect and copy; the right to amend; the right to an accounting of disclosures; the right to request restrictions; the right to a paper copy of this notice; the right to request confidential communications.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. Precision Eye Care may condition treatment upon the execution of this Consent.

Authorization for Use/Disclosure of Information: I voluntarily consent to authorize Precision Eye Care providers and their respective assistants to use or disclose my personal health in formation during the term of this Consent to the following recipient(s):

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Term: I understand that this Consent will remain in effect for one year from the date signed below.

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Consent or applicable federal and state law governing the use and disclosure of my personal health information.

Patient Signature: ___________________________________ **Date:** ______________

(If a minor, Parent/Guardian)