HIPAA PRIVACY POLICY PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health insurance portability and accountability act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- *Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)*
- *Obtaining payment from third party payers (i.e. my insurance company)*
- *The day to day healthcare operation of our practice*

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payments and health care operations but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signature: ____ **Date:** ________________

Voicemail Messages:
I also give permission to the doctors and staff at Blvd Eyes to leave voicemail messages concerning my appointments and test results. I understand it is my responsibility to inform the office of any changes in this information.

Please leave information at the following phone numbers:

Primary # ____________________ **Secondary#** ____________________

Mailings:
I also give my permission to mail reminder postcards regarding appointments to my home address. I understand it is my responsibility to inform the office of any changes in this information.

Signature: ____ **Date:** ________________