

HERITAGE EYE CARE HIPAA NOTICE & DISCLOSURES

In the course of providing services to you, Heritage Eye Care creates, receives and stores health information that identifies you. It is often necessary to use and disclose the health information in order to treat you, to obtain payment for our services, and to conduct health care operations in our office. The *Notice of Privacy Practices (NPP)* you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our *NPP*, the uses and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes: our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; our submission of your health information to auditors hired by third-party payers and insurers; as well as other aspects of payment described in our *NPP*. When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have been provided with a copy of our *NPP*.

PATIENT SIGNATURE _____ DATE _____

PERMISSION TO SHARE HEALTH INFORMATION

This form states that you have read our *Notice of Privacy Practices (NPP)* and understand how seriously we take your privacy, but are obligated to release medical information under certain legal conditions as described therein. Sometimes you may wish to have only certain parts (or medical conditions) of your medical records to be released to only certain physicians or people. If you want to restrict this information, this part of the disclosure form allows you to list what information and to whom it may be released. By signing below, I give permission to the person(s) listed in the table documented to receive information about my care. This permission will be considered ongoing until I state in writing otherwise.

Date of Permission	Name of Individual & Relationship to Patient	Comments/Instructions <i>(ie. may pick up prescription, ect.)</i>	Patients Initials

In order to obtain information by telephone, the party calling the practice must be able to share the patient identifier/password with the staff.

Patient Chosen Identifier/Password: _____

PATIENT SIGNATURE _____ DATE _____