



# SUN CITY CENTER EYE CLINIC and COSMETIC CENTER

Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

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Please list the family members or significant others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY**.

Name \_\_\_\_\_ Phone number \_\_\_\_\_

Name \_\_\_\_\_ Phone number \_\_\_\_\_

Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home.

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Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL."

YES \_\_\_\_\_ NO \_\_\_\_\_

Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or other health care information if other than your home number.

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**\*I am fully aware that a cell phone is not a secure and private line.**

Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voicemail?

YES \_\_\_\_\_ NO \_\_\_\_\_

PATIENT NAME \_\_\_\_\_ (guardian if under 18)

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_



# SUN CITY CENTER EYE CLINIC and COSMETIC CENTER

## Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

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**PATIENT NAME**

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**DATE**

**I understand** that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain Patient Rights regarding my protected health information.

**I understand** that Sun City Eye Clinic may use or disclose my protected health information for treatment, payment or health care operations-which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Sun City Eye Clinic has a detailed document called the '**Notice of Privacy Practices**'. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

**I understand** that I have the right to read the 'Notice' before signing this agreement. If I ask, Sun City Eye Clinic will provide me with the most current Notice of Privacy Practices.

**My signature** below indicates that I have been given the chance to review such copy of the Notice of Privacy Practices. My signature means that I agree to allow Sun City Eye Clinic to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Sun City Eye Clinic has taken action relying on this consent.

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**SIGNATURE** (Patient or Legal Custodian/Authorized Representative)

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**DATE**

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**Relationship to Patient** if signed by another party

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**DATE**

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our 'Notice' at any time by contacting: Sun City Eye Clinic, 1701 Rickenbacker, Sun City, Florida 33573, 813-634-8877.