BRANDON CATARACT CENTER
AND EYE CLINIC

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

PATIENT NAME _____ **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 Brandon Eye Clinic may use or disclose my protected health information for treatment, payment or health care operation-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.

Brandon Eye Clinic has a detailed document called the ***'Notice of Privacy Practices'.*** It contains a more complete desciption 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, Brandon 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 Brandon Eye Clinic to use and disclose my protected health information to carry our treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Brandon Eye Clinic has taken action relying on this consent.

_____ _____

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

_____ _____

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

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our 'Notice' at any time by contacting: The Brandon Eye Clinic, 403 Vonderburg Drive, Suite 101, Brandon, Florida 33511

BRANDON CATARACT CENTER AND EYE CLINIC

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

_____

_____

Please list the family memers 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.

_____

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 recieve calls about your appointments, lab and x-ray results. or other health care information if other that your home number.

_____

*** I am fully aware that a cellphone 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_____