PATIENT CONSENT TO USE AND DISCLOSE HEALTH INFORMATION FORM

The federal government Health Insurance Portability and Accountability Act of 1996 (HIPAA), was issued to protect the privacy rights of patients. Federal and state laws require our office to protect the privacy of your records. However, absolute confidentiality cannot be guaranteed because of the need to disclose information for treatment, payment, and/or healthcare operations. In compliance of HIPAA, the completion of this office form is required.

I, ______________________________, understand that as part of my care and office visit, Drs. Phillips and Csonka and The Eye Care Center, originate and maintain paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatments, fees, and plans for future care or treatment. I understand that this information serves as:

- A basis from planning my care and treatment,
- A means of communication among health professionals who contribute to my care,
- A source of information for third-party verification of my diagnosis and applied information to my bill,
- A tool for our routine healthcare operations
- A contribution for public health/ good (Product recalls, Law Enforcement, Court Order, CDC)

I understand that I can request a copy of the **Notice of Privacy Practices** that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to my signing this consent,
- The right to object to the use of my health information for directory, and
- The right to request restrictions as to how my heath information may be used for disclosure to carry out treatment, payment, or health care operations.

I understand that I have the right to inspect, correct, or have a copy of my Personal Health Information (PHI). I understand that The Eye Care Center (TECC) is allowed up to 30 days to either grant or deny this request. There may be a copy fee. TECC is not required to agree to the request. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I understand that by refusing to sign this consent or revoking this consent, that I may refuse to be treated as permitted by Section 164.506 of the Code of Federal Regulations. I further understand that The Eye Care Center reserves the right to change their notice and practices, in accordance with Section 164.520 of the Code of Federal Regulations. You will be notified should there be a known breach to your information.

I wish to have the following restrictions to the use or disclosure of my health information:

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I understand that as part of this organization's treatment, payment activities, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses including disclosures via fax. If you change your mind to this consent, you must notify us in writing.

I FULLY UNDERSTAND AND ACCEPT THE TERMS OF THIS CONSENT, AND I ACKNOWLEDGE THAT I CAN ASK FOR A COPY OF THIS FORM AND A COPY OF THE PRIVACY PRACTICES.

Patient or Legally Authorized Representative Signature: ______________________________

Date of Signature: ____

179 York Road. Warminster, PA. 18974/ 215.674.2020