

Questions? 877-508-2020

HEALTH INSURANCE PORTABILITY ACCOUNTABILITY ACT ACKNOWLEDGEMENT

(PLEASE COMPLETE THIS FORM AND BRING IT TO YOUR PRE-OPERATIVE APPOINTMENT.)

I, _____, understand that, as part of my health care, Restore Vision Centers originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations, such as accessing quality and reviewing the competence of healthcare professionals.

I understand that I have the following rights and privileges per the *Notice of Privacy Practices* (this document is available upon request):

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

I understand that Restore Vision Centers is not required to agree to the restrictions requested. 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 also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by *Section 164.506 of the Code of Federal Regulations*.

I further understand that Restore Vision Centers reserves the right to change their notice and practices, and prior to implementations, in accordance with *Section 164.520 of the Code of Federal Regulations*. Should Restore Vision Centers change their notice, they will send a copy of any revised notice to the address I have provided. My preferred method of receiving mail is U.S. Mail Email No preference

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

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosures for these permitted uses, including disclosures via fax.

BY SIGNING BELOW, I ACCEPT THE ABOVE STATEMENT AND TERMS OF THIS CONSENT.

Patient's Signature

Date

FOR OFFICE USE ONLY

- () Consent received by _____ on _____
- () Consent refused by patient, and treatment refused as permitted
- () Consent added to patient's medical record on _____