YOUR MEDICAL RECORDS AND YOUR RIGHTS TO PRIVACY

As a patient, the release of your medical information is limited to those parties directly involved in your care or payment for your care. Please take a moment to read and sign the summarized Notice of Information Practices which describes your rights.

NOTICE OF INFORMATION PRACTICES

1. Piedmont Eye Center, Inc. may use and disclose protected health information for treatment, payment, and healthcare operations. Examples: referrals, nursing homes, pharmacies, hospital referrals, drug assistance programs, and low vision rehabilitation programs. Payment examples include: insurance companies and collection agencies. Healthcare operations include: electronic billing and auditing medical records.
2. In certain circumstances under state and federal laws, Piedmont Eye Center, Inc. is required to disclose protected health information without the individual's written consent or authorization. An example of such are for public health requirements or court orders.
3. Piedmont Eye Center, Inc. will not make any other use or disclosure of a patient's protected health information without the individual's written authorization.
4. Piedmont Eye Center, Inc. reserves the right to change the terms of its notice and to make new provisions effective for all protected health information that it maintains.
5. Any patient, guardian or personal representative has the right to request, inspect and obtain copies of his/her medical record, request amendments be made to his/her medical record, request to receive confidential communications of protected health information by alternative means or at alternative locations, request a six-year accounting of all disclosures of his/her medical records and to request restriction as to how their health information may be used or disclosed to carry out treatment, payment or healthcare operations.
6. All such requests must be in writing and the practice must accommodate reasonable request.
7. Any person/patient may file a complaint with the Practice and with the Secretary of Health and Human Services if he/she believes his/her privacy rights have been violated. No retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance of the privacy standards.

In addition, you may provide a list of relatives, spouse, friends, care givers etc. that have your permission to access your health information if they should call our practice on your behalf. By law, we will not be able to disclose any part of your examination or billing information with any individual unless their name appears on your list. The caller will be asked to verify certain information about you prior to the disclosure of your protected information. (provide your list on the **back of this page**).

CONSENT FORM

(For use and disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations)

I understand that my health information serves as: A basis for planning my care and treatment, a means to communicate among health professionals, a source of information for applying my diagnosis to my bill, a means by which a third party payer can verify that services billed were actually provided.

I understand and have been provided with a Notice of Information Practices that provided a summary description on information uses and disclosures. I notice that I have the right to review the comprehensive notice on file with the practice, prior to signing this consent.

With this consent, Piedmont Eye Center, Inc. may call my home or other designated locations and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory and test results among others.

With this consent, Piedmont Eye Center, Inc. may e-mail to me appointment reminders and patient statements. I have the right to request that Piedmont Eye Center, Inc. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound to this agreement.

By signing this form, I am consenting to Piedmont Eye Center, Inc. to use and disclose my PHI to carry out my TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. **If I do not sign this form, Piedmont Eye Center, Inc. may decline to provide treatment to me.**

SIGNATURE of PATIENT or Legal Guardian: _____

PATIENTS DATE OF BIRTH: ____ / ____ / _____ DATE SIGNED:____ / ____ / _____

over

Piedmont Eye Center, Inc. has permission to discuss my healthcare and billing information with the following family members or other personal contacts, including spouse, friends, care givers, etc.

NAME	**RELATIONSHIP**
_____	_____
_____	_____
_____	_____

SIGNATURE of PATIENT or Legal Guardian: _____

PATIENTS DATE OF BIRTH: ____ / ____ / _____ DATE SIGNED: ____ / ____ / _____