THE EYE STORE

NOTICE OF PRIVACY PRACTICES CONSENT TO USE AND DISCLOSE PROTECTED INFORMATION

The Eye Store is responsible to maintain the privacy of your health information and required by the Federal Government to provide you with this Privacy Practices and how it relates to your Ophthalmic and Optical information.

Your Ophthalmic and/or Optical information may be used by staff members or disclosed to other health care professionals that you may seek services from for the purpose of evaluating your ocular needs.

Your Ophthalmic and/or Optical information may be used to obtain payment from your health plan or credit card companies that you may use for payment of services.

Your information may also be used by our staff to send you appointment reminders, or to send you information on the treatment and management of your ocular condition. We may also send you information regarding other ophthalmic and/or optical related products or services that may be of interest to you.

Patients have certain rights under the Federal Privacy Standards.

- You have the right to request restrictions on the use of your health information (Ophthalmic and/or Optical), which must be submitted in writing.
- You have the right to request confidential communications concerning your ophthalmic condition or optical information.
- You have the right to receive a copy of your health information (Ophthalmic and/or Optical).
- You have the right to receive an accounting of how and to whom your health information has been disclosed.

☐ **The HIPAA Notice of Privacy Practices was available to read during my office visit. _____ (Please Initial)**

_____

Name of Patient (Print Clearly)

_____

Date

_____

Signature of Patient OR Patient Representative

_____

If Applicable Relationship of Patient Representative to Patient

TWO SIDED FORM ***TURN OVER***

Authorization for Release of Identifying Health Information for Family and/or Friends:

I authorize the release of my information including the examination results, diagnosis, records, and claims information.

This information may be released to:
Name(s) and Relationship:

_____

_____

_____

☐ Information is NOT to be released to anyone.
Check this box if you do not want anyone to have any access to your information

_____

Printed Name of Individual Giving this Authorization

_____

Date of Birth of Individual Giving this Authorization

_____

Signature (Patient or Authorized Individual for Patient)

_____

Date

This Authorization for Release of Information will remain in effect until terminated by me in writing.

TWO SIDED FORM ***TURN OVER***