Revised 08/2017

HIPAA – Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for your treatment, payment, and health care operations. You have the right the revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made is reliance on your prior Consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of the Consent.

I, ______________________________, authorize Tasman Eye Consultants to release healthcare information to any one listed below: (Please list names and phone/fax numbers)

____

____

____

I fully understand and ACCEPT / DECLINE (circle one) the terms of this consent.

____ ______________________

Patient Signature (Parent/Guardian if child) Date

Document expires one year from date of signature.

We are now making greater use e-mail to communicate with our patients. To help us provide the most prompt service possible, please provide us with your current e-mail address and whether your accept e-mails and/or text messaging. *NOTE: All patient information is kept strictly confidential.

E-mail address:	
If we have something important to tell you or we cannot contact you otherwise, would you like a text message sent to your cellular phone?	O Yes O No Cell Phone #:
Can we send appointment reminders, communicate if your glasses or contacts are ready, and send other important information by e-mail?	O Yes O No