RICHMOND EYE CARE
HIPAA ACKNOWLEDGEMENT FORM FOR PRIVACY PRACTICES

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

TO THE PATIENT – Please read the following statements carefully.

PURPOSE OF CONSENT – By signing this form, you will consent to our use and disclosure of your protected information to carry out treatment, payment activities, and healthcare operations.

NOTICE OF PRIVACY PRACTICES – You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the use and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice is available at the reception desk.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our Privacy Practices, we will issue a revised Notice of Privacy Practices, which will contain current changes. Those changes may apply to any of your protected health information that we maintain.
You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our office.

RIGHT TO REVOKE – You have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the Privacy Officer, 1770 N. Parham Rd, Suite 101, Henrico, VA, 23229.

PLEASE FILL OUT

I, ______________________________________, have had the full opportunity to read and consider this Consent from and am giving my consent to your use and disclosure of my protected health information as described in the Notice of Privacy Practices.

(The short of it, is that we only use your information to consult with other providers to coordinate your care. And we cannot discuss your conditions with your family members without your agreement. – Dr. Shows)

I allow the following people to discuss/receive information about me:

____

Do we have your permission to:

Communicate using e-mail?	□ Yes	□ No
Communicate using texting?	□ Yes	□ No

____ __________________

Signature of Patient or Patient's Representative Date

If this Consent is signed by a representative on behalf of a patient, please indicate:

Relationship to Patient ________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

FOR OFFICE USE ONLY

____ Patient declined to sign. Reason, if known _________________