LEANN M. BURNS O.D.
UP NORTH EYE CARE

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change and if so you will be notified at your next visit to update your signature/date.

You have the right to restict how your private health information is used and disclosed for treatment, payment or heatlthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of information for the treatment, payment, or healthcare operation.

By signing this form you consent to our use and disclosure of your protected healthcare informaion and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected Health information may be disclosed and used for treatment, payments or healthcare operations;
- The practice reserves the right to change the privacy policy allowed by law;
- The patient has the right to restrict the use of the information, but the practice does not have to agree to those restrictions;
- The patient has the right to revoke the consent in writing at any time and all full disclosure will then cease;
- The practice may condition receipt of treatment upon the execution of this consent.

May we phone, you to confirm appointment or let you know product is ready? Yes No

May we leave a message on your answering machine at home or on your cell phone? Yes No

May we discuss your medical condition with any member of your family? Yes No

if **YES**, please name (**First and Last name**) the members allowed:

_____

_____

_____

_____

_____

Patient Signature:_____ Date: _____

Print Name: _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to patient: _____ Source of Authority: _____