Notice of Privacy & PHI

Patient: _____ Date: _____

PLEASE REVIEW THIS NOTICE CAREFULLY
As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

OUR COMMITMENT TO YOUR PRIVACY: Our practice is dedicated to maintaining the privacy of your individually identifiable health information [personal health information or PHI] as protected by law, including the Health Information Portability and Accountability Act (HIPAA).

In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI.

By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time. We realize that these laws are complicated, but we must provide you with the following important information:
How we may use and disclose your PHI
Your privacy rights in your PHI
Our obligations concerning the use and disclosure of your PHI
Your records may be electronically submitted to your insurance provider on your behalf for claims filing or other information as requested / needed by them.
The terms of this notice apply to all records containing your PHI that are created or retained.

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM and ELECTRONIC RECORDS TRANSFER.

I have been offered a copy of the Jeffries Eye Associates' notice of privacy practices and give my permission for electronic records release for insurance, claims, and billing purposes on my behalf.

X_____
SIGNATURE OF PATIENT (Guardian or Parent Signature, if minor)

PERSONAL HEALTH INFORMATION RELEASE: Due to confidentiality laws, it is necessary for us to have written authorization to share your personal information with *friend or family member* should you become incapacitated or unable to deal with your business affairs for any reason**. Please list any individuals you would utilize in case of this event**.

I authorize Jeffries Eye Associates to release necessary medical and /or financial information about myself to:

_____ _____
(name) (relationship)

_____ _____
(name) (relationship)

_____ _____
(name) (relationship)

X_____
SIGNATURE OF PATIENT (Guardian or Parent Signature, if minor)

Jeffries Eye Associates
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