LIFESTYLE EYE CENTER
Healthy You – Healthy Eyes

PRIVACY NOTICE FOR PATIENTS

Use and Disclosure of Protected Health Information

Our Privacy Notice gives detailed information about how we may use and share your protected health care information. It complies with the latest updates to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). A copy is included in your mailing and is available at the front desk of our office.

While you may request restrictions on the use and sharing of your protected health information, we are not bound to comply for reasons listed in our Privacy Notice.

If we change the terms of the Privacy Notice, we will display the new policy and its effective date in our office.

Lifestyle Eye Center accesses your medication history electronically to quickly and securely obtain information.

Use of Patient Contact Methods

Please let us know on your patient registration form how you prefer to be contacted, e.g. phone, email or physical mail. If we are unable to reach you by phone we may leave a message. We might also leave you an automatic notification or an appointment reminder by email. Let us know if any of your contact methods are not suitable for leaving messages.

Acknowledgement & Consent Form for Use and Disclosure of Information

By signing below, I acknowledge I have received a copy of the Privacy Notice and consent to allow Lifestyle Eye Center to use and share protected health information about me for treatment, payment, and other health care operations as described in the Privacy Notice. I understand I can revoke this consent in writing, except where information has already been shared because of prior consent. I understand if I have any questions I may contact the office at (509) 540-3937.

Signature of Patient or Authorized Party: _____ Date: _____

Print Name and Relationship (if not patient): _____

Personal Representative, Family or Other Entities Authorized Access to Protected Health Information

Name or specifically identify those persons and/or other entities you are authorizing to make use of and/or disclose your protected health information regarding treatment, payment, and other healthcare operations or concerns.

Name of Authorized Person or Entity: _____ Relationship: _____

Phone #: _____

Name of Authorized Person or Entity: _____ Relationship: _____

Phone #: _____

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