Security of Patient Information

retina CARE CENTER

TO OUR PATIENTS:

The privacy of your health care information is extremely important to us. We want you to understand how we use and disclose your information. We ask you to review our Notice of Privacy Practices that describes our legal duties to your health care information.

HOW WE USE HEALTH CARE INFORMATION:

We do not require verbal approval from the patient to share private health information with family or others when we feel it's in the patient's best interest to share appointment or health care information. This means we will answer family questions, and confirm appointment information if the inquiry is made on behalf of a patient. If you do not agree with our policy, please indicate your wishes regarding the handling of your health information.

- ○ **I AGREE** with the policy above.
- ○ **I DO NOT AGREE** with the policy above and wish for my health information to be shared only with myself.

Signature: _____ Date: _____

WE USE INFORMATION ABOUT YOU TO:

1. Provide treatment to you.
2. Ensure appropriate payment for the treatment we provide.
3. Monitor the quality of our operation.

PERMITTED DISCLOSURES:

In certain cases we are permitted to disclose health care information about you. Examples include when there is a serious threat to health or safety, for worker's compensation, to reduce public health risks, for health oversights and in certain cases of law enforcement. In addition, we may disclose information to tell you about health-related services and alternative treatments and to conduct health-related research with your permission.

Acknowledge and Consent

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YOUR INFORMATION RIGHTS

I understand that Retina Care Center (referred to below as "This Practice") will use and disclose health information about me.

I understand that my health information may include information both created and received by The Practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions and similar types of health-related information.

I understand and agree that This Practice may use and disclose my health information in order to:

1. Make decisions about and plan for my care and treatment;
2. Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
3. Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
4. Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

Please sign below that you understand/have received our Notice of Privacy Practices. If you have any questions, please ask to speak with medical records. If you would like a pamphlet of the Notice of Privacy Practices, please ask for one at the front desk.

Signature: _____ Date: _____

Print Name: _____

OR

By (Patient Representative): _____ Date: _____

Description of Representative's Authority: _____