Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

Patient Name: ______________________________________ Date: __________________

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected Health Information.

I understand that TrueSight Eye Health may use or disclose my protected health information for treatment, payment, or healthcare operations-which means for providing health care to me, the patient; handling billing and payment; and taking care of other healthcare operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

I understand that I have the right to read the 'Notice' before signing this agreement. If I ask, TrueSight Eye Health will provide me with the most current Notice of Privacy Practices.

My signature below indicates that I have been given the chance to review such copy of the Notice of Privacy Practices. My signature means that I agree to allow TrueSight Eye Health to use and disclose my protected health information to carry out treatment, payment, and healthcare operations. I have the right to revoke this consent in writing at any time, except to the extent that TrueSight Eye Health has taken action relying on this consent.

Signature: ____

Relationship to Patient (if signed by another party): ______________________________________

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our "Notice" at any time by visiting our website or calling our office.

www.truesighteyehealth.com Phone: 1-248-526-1010