Patient HIPAA Acknowledgment and Consent Form

SEES Management Solutions

Please indicate which doctor you were referred to see:

☐ Kostamaa ☐ Ludwig/Children's Eye Care of the South ☐ Nguyen

Patient Name:_____ Date:_____/_____/_____

Date of Birth:_____/_____/_____ Account Number:_____

Notice of Privacy Practices: I acknowledge that I have received or have been offered the Practice's Notice of Privacy Practices. Initial ONLY if Notice of Privacy Practices refused by patient or patient's representative. _____(Patient Initials)

Release of Information: I hereby authorize this Practice to release to referring or subsequent healthcare providers, reports of my medical condition that will assist him or her in my continued medical care, and as needed, to process claims and for general healthcare operations, which may include the use of an electronic health information exchange. I further authorize this Practice to retrieve information about my current medications from third-parties in order to assist in my care and correct payment of claims.

Disclosure to Family Members and/or Friends: HIPAA allows this Practice to communicate with your family and friends who are involved in your treatment or payment for your treatment. However, you have the right to direct this Practice not to share your Protected Health Information (PHI) at all, or to specifically restrict or deny the Practice's ability to share your PHI with individuals you may name. Please check below if you wish to OPT OUT of this Practice's communicating with friends or family entirely OR complete the information below to identify those individuals with whom the Practice is NOT TO COMMUNICATE. *If both are left blank, Practice will share PHI with family and friends in accordance with privacy regulations and professional judgment.*

_____**I DO NOT WISH** for the Practice to communicate about my treatment or payment with family or friends.

_____The practice may communicate about my treatment to family and friends, **EXCEPT** for the following individuals:

First and Last Name	Relationship to Patient

Consent for Photographing or Other Recording for Security, Health Care Operations, and/or Education:

_____(Patient Initials) ☐ **I Consent** OR ☐ **I do not Consent** to photographs, videotapes, digital recording, digital or analog audio recordings, and/or images of me being recorded for security purposes, Practice's health care operations (e.g. quality improvement activities), and/or continuing medical education (CME). I understand the facility retains ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected in compliance with HIPAA. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment, or healthcare operation purposes or otherwise permitted or required by law.

Patient HIPAA Acknowledgment and Consent Form (cont.)

Consent to email, text message or receive automated calls for appointment reminders and other healthcare communications: Patients in our Practice may be contacted via email, text message, or automated phone call to remind you of an appointment, to obtain feedback on your experience with our healthcare team and to provide general health reminders/information. *Standard text messaging rates may apply. Contact your cell service provider for details*.

Please indicate which method you prefer for appointment reminders and other health care communications. Patient's preferences shall remain in place until changed by patient in writing.

_____(Patient Initials) **Text Message:** I authorize Practice to send text messages for appointment reminders, feedback, and general health reminders to the cell number indicated here (10 digits):_____

_____(Patient Initials) **Email:** I authorize Practice to send appointment reminders, feedback and general health information to the email address indicated here:
Email Address:_____

_____(Patient Initials) **Automated phone call:** I authorize Practice to place automated phone calls to the cell phone or landline phone indicated here:
Phone number (10 digits):_____ ☐ Cell ☐ Landline

I understand that once my PHI is disclosed to a third party, that party may disclose my information to other parties and any re-disclosure of my PHI by a third party may no longer be protected under federal or state privacy laws.

I understand that PHI may include including information relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia or HIV infection.

Patient may revoke or modify any of these consents by completing a new HIPAA Acknowledgement and Consent Form. Any disclosures made prior to the date of revocation or modification will not be affected.

Patient/Legal Guardian Signature:_____ Date:_____

Patient Name (Printed):_____ Account Number:_____