Plessen Ophthalmology – Patient HIPAA Acknowledgment & Consent Form

Patient Name:_____ Date: _____

Date of Birth:_____ Account #: _____

Notice of Privacy Practices: I acknowledge that I have received or have been offered the Center'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 about your treatment, or payment for your treatment, with family and friends who you have selected. Please indicate which friends or family members this Practice may communicate with regarding your PHI in the space below. ***Please note that if family or friends who are NOT listed below request your PHI, the Practice will solicit your consent PRIOR to providing PHI to that individual – OR – Practice will use its best professional judgment to decide if PHI should be shared with the requestor. If best professional judgment is used, Practice will document the name of the requester, the relationship to patient, the date of the disclosure and the specific information shared with the requestor.***

First and Last Name	Relationship to Patient

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.

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

Consent for Photographing or Other Recording for Security, Health Care Operations, and/or Education:
_____ (Pt 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.

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.***

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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: (___-_____-_____)

- _____ (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: (____-_____-____) Is this a Cell or Landline? (Circle one)

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)	Acct#