HIPAA – USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I acknowledge that I have received or have been offered a copy of The Medical Eye Center's Notice of Privacy Practices, which provides information about how the practice and individuals involved in my care in the practice may use and disclose my protected health information. I also understand that if the current notice is ever amended, the updated "Notice of Privacy Practices" will be made available to me.

PERMISSION TO VERBALLY DISCUSS PROTECTED HEALTH INFORMATION

Per The Medical Eye Center's notice of privacy practices, the practice has permission to disclose your medical and billing information with your current healthcare providers. If there is someone on a personal level (family members, friends, etc.) who you would like to have access to your medical and billing information on your behalf, please provide their information in the provided spaces below. Check off "I decline" below if there is no one you would like to add to speak on your behalf.

- Medical information, including my symptoms, diagnosis, medications and treatment plan
- Billing and payment information

The Medical Eye Center has permission to discuss the above information with:

NAME	TELEPHONE NUMBER	RELATIONSHIP

☐ I decline permission to discuss medical information with anyone but myself

PRINT NAME OF PATIENT	SIGNATURE OF PATIENT	DATE