Southern Kentucky Eye Center

HIPAA COMPLIANCE PATIENT CONSENT FORM SOUTHERN KENTUCKY EYE CENTER

OUR NOTICE OF PRIVACY PRACTICES PROVIDES INFORMATION ABOUT HOW WE MAY USE OR DISCLOSE PROTECTED HEALTH INFORMATION.

THE NOTICE CONTAINS A PATIENT'S RIGHTS SECTION DESCRIBING YOUR RIGHTS UNDER THE LAW. YOU ASCERTAIN THAT BY YOUR SIGNATURE THAT YOU HAVE REVIEWED OUR NOTICE BEFORE SIGNING THIS CONSENT.

THE TERMS OF THE NOTICE MAY CHANGE IF SO, YOU WILL BE NOTIFIED AT YOUR NEXT VISIT TO UPDATE YOUR SIGNATURE/DATE. YOU HAVE THE RIGHT TO RESTRICT HOW YOUR PROTECTED HEALTH INFORMATION IS USED AND DISCLOSED FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS.

WE ARE NOT REQUIRED TO AGREE WITH THIS RESTRICTION, BUT IF WE DO, WE SHALL HONOR THIS AGREEMENT. THE HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996) LAW ALLOWS FOR THE USE OF THE INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS. BY SIGNING THIS FORM, YOU CONSENT TO OUR USE AND DISCLOSURE OF YOUR PROTECTED HEALTH CARE INFORMATION AND POTENTIALLY ANONYMOUS USAGE IN A PUBLICATION. YOU HAVE THE RIGHT TO REVOKE THIS CONSENT IN WRITING, SIGNED BY YOU. HOWEVER, SUCH A REVOCATION WILL NOT RE RETROACTIVE.

CONSENT TO WIRELESS TELEPHONE CALLS AND EMAIL USAGE

IF AT ANYTIME I PROVIDE A WIRELESS TELEPHONE NUMBER OR EMAIL ADDRESS, AT WHICH I MAY BE CONTACTED, I CONSENT TO RECEIVE CALLS OR TEXT MESSAGES, INCLUDING, BUT NOT RESTRICTED TO COMMUNICATIONS REGARDING BILLING AND PAYMENT FOR ITEMS AND SERVICES, UNLESS I NOTIFY, SKEC TO THE CONTRARY IN WRITING. IN THIS SECTION, CALLS AND TEXT MESSAGES INCLUDE, BUT IS NOT RESTRICTED TO PRE RECORDED MESSAGES, ARTIFICIAL VOICE MESSAGES, AUTOMATIC TELEPHONE DIALING DEVICES OR OTHER COMPUTER ASSISTED TECHNOLOGY, OR BY ELECTRIC MAIL, TEXT MESSAGING OR BY ELECTRONIC MAIL, TEXT MESSAGING OR BY ANY OTHER FORM OF ELECTRONIC COMMUNICATION FROM THE OFFICE, AFFILIATES, CONTRACTORS, SERVICERS, CLINICAL PROVIDERS, ATTORNEYS, OR ITS AGENTS INCLUDING COLLECTION AGENCIES. I CONSENT TO RECEIVE PORTAL INSTRUCTIONS, STATEMENTS, BILLS, MARKETING MATERIAL FOR NEW SERVICES AND PAYMENT RECEIPTS AT THE EMAIL ADDRESS FROM THE OFFICE OF SKEC.

BY SIGNING THIS FORM, I UNDERSTAND THAT:

PROTECTED HEALTH INFORMATION MAY BE DISCLOSED OR USED FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATION.

THE PRACTICE RESERVERS THE RIGHT TO CHANGE THE PRIVACY POLICY AS ALLOWED BY LAW.

THE PRACTICE HAS THE RIGHT TO RESTRICT THE USE OF THE INFORMATION BUT THE PRACTICE DOES NOT HAVE TO AGREE TO THOSE RESTRICTIONS.

THE PATIENT HAS THE RIGHT TO REVOKE THIS CONSENT IN WRITING AT ANY TIME AND ALL FULL DISCLOSURES WILL THEN CEASE.

THE PRACTICE MAY CONDITION RECEIPT OF TREATMENT UPON EXECUTION OF THIS CONSENT.

- MAY WE PHONE,EMAIL, OR SEND A TEXT TO YOU TO CONFIRM APPOINTMENT:
- [ ]YES [ ] NO
- MAY WE LEAVE A MESSAGE ON YOUR ANSWERING MACHINE AT HOME OR ON YOU CELL PHONE:
- [ ]YES [ ]NO
- MAY WE DISCUSS YOUR MEDICAL CONDITION WITH ANYONE OTHER THAN YOURSELF:
- [ ]YES [ ]NO

IF YES PLEASE NAME OF THE ALLOWED TO RECEIVE YOUR MEDICAL INFORMATION

1.

2.

3.

4.

5.

SIGNATURE: _____ DATE: ____/_____/_____