HIPAA Privacy Form

Notice of Privacy Practices-Right to Notice

As a patient, you have the right to adequate notice of the uses and disclosures of your protected health information. Under the Health Insurance Portability and Accessibility Act (HIPPA). Cottage Grove Eye Care can use your protected health information for treatment, payment, and health care operations.

Treatment: We may use or disclose your health information to a physician or other healthcare provider that is providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for the services that we provide you.

Health Care Operations: We may use and disclose your health information in connection with our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competency or qualifications of healthcare professionals, evaluating provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may use or disclose your health information to provide you with appointment reminders via phone, email, or letter.

Cottage Grove Eye Care will obtain your written authorization for any disclosures that do not fall under treatment, payment, or health care operations. Upon signing, you may revoke your authorization (in writing) through our practice at any time. In an event of your incapacity or an emergency situation, Cottage Grove Eye Care will disclose your health information to _____________________________________, or another person that is responsible for your care, using our professional judgment. We will only disclose health information that is directly relevant to the person's involved in your healthcare.

Cottage Grove Eye Care will not use your health information for marketing communications without your written authorization. We may also use or disclose your health information when required to do so by law. We may disclose your health information to appropriate authorities if we believe that you are a possible victim of abuse, neglect, or domestic violence or other crimes. We may disclose health information to the external necessary to avert a serious threat to your or other people's health or safety.

Cottage Grove Eye Care may disclose the health information of Armed Forces personnel to military authorities under certain circumstances. We may disclose health information to authorized federal officials required for lawful intelligence, counterintelligence and other national security activities. We may disclose health information of inmates or patients to the appropriate authorities under certain circumstances.

You have the right as a patient to restrict the disclosure of your protected health information (in writing). The request for restriction may be denied if the information is required for treatment, payment, or health care operations. You have the right to receive confidential communications, inspect and copy, or amend your protected health information. You have the right to receive an account of disclosures regarding your protected health information and you may receive a paper copy of this privacy notice.

Cottage Grove Eye Care is required by law to maintain the privacy of your protected health information and are required to abide by the terms of this notice as it is currently stated, we also reserve the right to change this notice. The policies in any new notice will not be in effect until they are available within our office. If you have complaints regarding the way your protected health information was handled, you may submit a complaint in writing to our office. You will not be retaliated against in any manor for a complaint.

427 W. Cottage Grove Rd. Cottage Grove, WI 53527 - Phone: 608.839.0980 - Fax: 608.839.0982

www.cgeyecare.net

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I have read and understand the Notice of Privacy Practices of Cottage Grove Eye Care and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request (in writing) that you restrict how my private information is used to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Name of Patient: (PRINT) ____

Date: ____________________________

Signature of Patient: ____

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the member identified above and I will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the member's behalf with respect to this authorization form.

Name of Legal Representative: (PRINT) ____

Date: _____________________________

Signature of Legal Representative: ____

Name of Witness: (PRINT) _____________________________________ Signature of Witness: __________________________________

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