Privacy Practices and Release of Information

Privacy Practices

Desert Retina Consultant's Notice of Privacy Practices provides information about how we may use and disclose Protected Health Information (PHI). The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Acknowledgement. The terms of our Notice may change. If we change our notice, you may receive a revised copy by contacting our office.

You have the right to request that we restrict how Protected Health Information about you is used or disclosed for treatment, payment, or healthcare operations. The law does not require Desert Retina Consultants to agree to this restriction, but if we do, we shall honor that agreement.

I acknowledge that I have been made aware of Desert Retina Consultants' privacy practices, which is posted in the waiting room. I understand that a copy of the Notice of Privacy Practices is available upon my request.

By signing this form, you consent to our use and disclosure of Protected Health Information (PHI) about you for treatment, payment, and healthcare operations. You have the right to revoke this Acknowledgement. Any revocation must be in writing and signed by you. Such revocation will not affect any disclosures we have already made in reliance on your prior Acknowledgement. Desert Retina Consultants provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Release of Information

I authorize the Desert Retina Consultants to release my Protected Health Information (PHI) to the following individual(s):

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Important Information

You have the right to terminate this authorization at any time by submitting a written and signed notice to our office. The revocation takes effect once it is received by our office, and does not apply to actions already taken before the revocation is received. You have the right to receive a copy of your signed authorization upon your request. Your signature below confirms your authorization and your understanding of this policy and your rights.

Patient Name: _____ Patient Date of Birth: _____

Patient/Responsible Party Signature: _____ Date: _____