NORTHWEST OPHTHALMOLOGY

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HIPPA Patient Consent Form

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to use or disclose your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). You may not revoke actions that have already been taken which relied on this or previously signed consent.

As stated above you may request that we communicate confidential health information to you by alternative means or in alternative locations. The Privacy Rule requires us to accommodate requests if reasonable.

Please indicate your request regarding communication from our office:

___ Please feel free to contact me at my home with confidential information

___ Do not contact me at my home with confidential information

___ Do not contact me at my work with confidential information

___ Please feel free to leave messages on my telephone answering machine

___ Do not leave messages on my telephone answering machine

___ I authorize this office to leave messages with persons at my home telephone

___ Please send confidential information to my home address

___ Please send confidential information to the following address:

_____

___ In urgent matters only, to be determined by my physician you may disclose pertinent information to: _____

Signature: _____ Date: _____