HIPPA CONSENT FORM

Consent to Use and Disclose Health Information

Permission to Use and Disclose Health information: By signing this form, I give permission to use and /or disclose my health information to provide treatment, obtain payment and conduct health care operations.

Right to Refuse: I have the right not to sign this consent. If I refuse to sign, Vision Associates(VA) has the right to refuse to treat me. However, treatment required by law-such as emergency care-can be provided to me whether or not I sign this consent

Changes to the Notice of Privacy Protection: VA may change the Notice of Privacy Practices as needed. I may obtain a current copy of the notice of privacy by contacting VA.

Right to Request Restrictions on Use/Disclosures: I have the right to request that the usage of my protected health information by VA be restricted in how it is used and disclosed for the purpose of providing treatment, obtaining payment, and/or conducting health care operations. VA is not required to agree to any restriction that I request. If VA does decide to agree to my request, the use and/or disclosure of my health information by VA must be restricted as I requested. If I wish to request restrictions, I can contact a supervisor. VA will notify me if the requests have been accepted or declined.

Right to Withdraw Consent: I have the right to withdraw this consent at any time. I must do so in writing. My withdrawal of this consent will not be effective for uses and disclosures that have already been made based on my prior consent. If I withdraw my consent, VA may refuse to provided to me further treatment or follow up, other than emergency services.

Effective Period: This consent is good unless and until I withdraw it in writing.

References to “I” or “me”: References to I or me in this consent include the individual for whom the signing party is authorized to sign. If I am signing this consent on behalf of another person, it is because I am that person’s parent, legal guardian, or agent under an active Power of Attorney or Health Care; and I am legally authorized to sign this consent on behalf of that person.

X____

Signature of patient or authorized representative *Date*

*X*____

Name of patient if not signed by patient

OFFICE USE ONLY

Complete this section if this form is not signed and dated by the patient or an authorized representative
I have made a good faith effort to obtain a written acknowledgment fo the Notice of Privacy Practices but was unable for the following reason.

Please circle

Patient refused to sign. Patient unable to sign. Other_________________________

____

Signature of Employee *Date*