Eye Doctors
OF WASHINGTON

Use and Disclosure of Protected Health Information:

This notice describes how patient healthcare information about you (as a patient of this Practice) may be used and disclosed, how you may obtain access to your health information, and how your patient rights affect the control of this health information. Our practice is required by law to maintain the privacy of your health information, and we are fully confident that our compliance with the policies described below will facilitate the proper protection of your health information.

I. Acknowledgement & Consent for the Use and Disclosure of Information

Our "Notice of Privacy Practices" policy, available at the reception desk and also online at our website, provides detailed information about how Eye Doctors of Washington (EDOW) may use and disclose protected health information about you. The details of this policy are in full compliance with all provisions, including those most recently updated, of the Health Insurance Portability and Accountability Act passed in1996 (HIPAA). Our "Notice of Privacy Practices" states that we reserve the right to change terms within our policy. Should this happen, we will display, and make available, the new policy and its perspective date of implementation. You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree with your restrictions; however, if we do, we are bound by our agreement with you.

By signing below, I acknowledge receipt of "Notice of Privacy of Practices" and consent to EDOW's use and disclosure of protected health information about me for treatment, payment, and health care operations. I have the right to revoke this consent, in writing, except where the practice has already made disclosures in trust on my prior consent.

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Patient's Signature Patient Full Name Date

II. Personal Representative, Family or Other Entities Authorized Access to Protected Health Information to be Used and/ or Disclosed:

Name or specifically identify these persons and/ or other entities you are authorizing to make use of and/or disclose your protected health information regarding treatment, payment, and other healthcare operations.

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Name of Authorized Person or Entity Relationship #Phone

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Name of Authorized Person or Entity Relationship #Phone

It is important to note that this authorization is not completely restrictive. In the case that these entities cannot be reached during an emergency that prompts immediate disclosure of protected healthcare information, EDOW reserves the right to use professional judgment as needed.

III. Authorization for use of Patient Contact Methods:

EDOW may be unable to contact patients directly during normal business hours. On these occasions our office contacts patients and leaves messages through the communication devices provided by our patients. Due to the new federally mandated HIPAA Privacy Rule, we must obtain your authorization to continue this mode of communication. Protected Healthcare Information that we may possibly disclose on your home, work, cell phone, or email account includes, but is not limited to: test/lab results, prescription/pharmacy information, appointment instructions for visits and procedures, and surgical posting/scheduling information.

☐ Yes, I agree to allow EDOW to leave messages that includes Protected Healthcare information on any of these communication devices: home phone, work phone, cell phone, and/or email account

☐ No, I do not agree to allow EDOW to leave messages that includes Protected Healthcare information on any of these communication devices: home phone, work phone, cell phone, and/or email account