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www.retinaone.com

Diplomate of the American Board of Ophthalmology
Diseases & Surgery of the Retina & Vitreous

Use and Disclosure of Protected Health Information

PATIENT ACKNOWLEDGEMENT & CONSENT FORM

The educational pamphlet entitled "**Notice of Privacy Practices**" provides information about how The Retina Centers of Washington may use and disclose protected health information about you, and is compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our **Notice of Privacy Practices** states that we reserve the right to change the terms described. Should this happen, you will receive a revised copy by mail (or explain your discretionary terms).

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 to your restrictions; but if we do, we are bound by our agreement with you.

Acknowledgement of Notification

By signing below, you acknowledge receipt of our Notice of Privacy Practices

X _____

Patient's Signature Date

Consent for Use and Disclosure of Information

By signing below, you consent to our use and disclosure of protected health information about you to your insurance carrier, family/private/referring physician for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

I request that payment of authorized Medicare/Insurance carrier benefits be made on my behalf to The Retina Centers of Washington for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare/ Medicaid Services and it's agent and/or any other Insurance Carriers for which I have coverage, any information needed to determine these benefits or the benefits payable for related services. I agree to provide all referral and treatment plan(s) as required by my insurance carrier(s). All co-pays must be paid at the time of service in accordance with the contracted Insurance Carrier agreements.

Patient's Signature Date

PRINT FULL NAME

Office use only

Date: _____ Initials: _____

(Over)

(Optional)

PERSONAL PREPRESENTATIVE, 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 to disclose your protected health information regarding treatment, payment and other healthcare operations.

Name of Authorized Person or Entity	Relationship	Phone#
Name of Authorized Person or Entity	Relationship	Phone#

AUTHORIZATION FOR USE OF ANSWERING MACHINE AND/OR VOICE MAIL

The Retina Centers of Washington physicians and healthcare staff routinely are unable to contact patients directly during normal business hours. On these occasions our offices leave messages on 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, or cell phone would include, but is not limited to: test/lab results, prescription/ pharmacy information, appointment instructions for visits and procedures, and surgical posting/ scheduling information.

_____ (Initial) Yes, I agree to allow The Retina Centers of Washington physicians and healthcare staff to leave messages that include Protected Healthcare Information on all three communication devices: home, work and cell phone.

_____ (Initial) I agree to allow The Retina Centers of Washington physicians and healthcare staff to leave messages that include Protected Healthcare Information on the following: Please **initial** next to the applicable communication devices:
_____home number, _____work number or _____ cell number.

_____ (Initial) No, I do not agree to allow The Retina Centers of Washington physicians and healthcare staff to leave messages that include Protected Healthcare Information on my home, work and cell phone.

Patient's Signature	Date