

Urban Eye Care

PATIENT ACKNOWLEDGEMENT OF HAVING READ OR BEEN READ THE NOTICE OF HEALTH INFORMATION PRACTICES.

I have been provided the opportunity to read, or it has been read to me, the Notice of Health Information Practices at Urban Eye Care.

I understand that Urban Eye Care is committed to treating and using protected health information about me responsibly.

I understand my rights as it relates to my records at Urban Eye Care and also understand how information about me may be used and disclosed.

I understand that Urban Eye Care is required to maintain the privacy of my health information.

Urban Eye Care will require my authorization to release my health information to outside sources with the exception of disclosures for purposes of Treatment, Payment and Healthcare. Operations. These may include: access to my health information by Urban Eye Care Staff and Physician, billing to myself or a third-party payer; In addition, business associates of Urban Eye Care. Urban Eye Care may from time to time, have access to my health information, but, I am assured that proper Business Associates Agreements are in place, insuring the protection of my health information, upon the physician's best judgement, he/she may disclose to a family member, relative, close personal friend or any other persons identified, health information relevant to that persons' involvement in my care may be used for research data, funeral directors, organ procurement, marketing, FDA, public health or legal authorities, and/or law enforcement purposes.

Urban Eye Care may call me with appointment reminders, cancellations, reschedules, bill inquires and may leave voice mail messages at my home or place of employment. I have read and understand the Health Information Practices of Urban Eye Care.

Medical Information Release Form
(HIPAA Release Form)

Name: _____

Date of Birth: _____

Release of Information

- I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released

to:

Spouse Name: _____ Child(ren) _____ Other: _____

Information is not to be released to anyone: _____

This ***Release of Information*** will remain in effect until terminated by me in writing.

Signed: _____

Date: _____

Witness: _____

Date: _____