Notice of Privacy Practices and Patient Consent
For Use and Disclosure of Protected Health Information

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PATIENT NAME **DATE**

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Castleman Eye Center may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Castleman Eye Center has a detailed document called the *'**Notice of Privacy Practices**'*. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the *'Notice'* before signing this agreement. If I ask, Castleman Eye Center will provide me with the most current *Notice of Privacy Practices*.

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices*. My signature means that I agree to allow Castleman Eye Center to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Castleman Eye Center has taken action relying on this consent.

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or any other healthcare related function. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to the receiving multiple messages per day from my healthcare provider, when necessary. I consent to allowing detailed messages on my voice mail, answering system, or with another individual, if I am unavailable at the number provided by me.

You may obtain a copy of our *Notice of Privacy Practices*, including any revisions of our *'Notice'* at any time by contacting: Castleman Eye Center 734-283-0500 or asking at our Registration Desk.

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SIGNATURE (Patient or Legal Custodian/Authorized Representative) **DATE**

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Relationship to Patient if signed by another party **DATE**

I give my permission for information to be released to the following: (Optional)

Name: Relationship:

Name: Relationship:

FORM Us