# HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is available upon request.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, health insurance payers as is necessary and appropriate for your care. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination rooms, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI, and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes in office policy and new technology that you might find valuable or informative, insurance items, and items pertaining to your clinical care.
3. You understand and agree to inspections of the office and review of documents which may include PHI by Government agencies or insurance payers in normal performance duties.
4. You agree to bring any concerns or complaints regarding privacy to the attention of the Privacy Officer at Lifetime Vision Care 1903 Tyrone Blvd. St. Petersburg, FL 33710.
5. We agree to provide patients access to their medical records in accordance with state and federal laws.
6. We may change, add, delete, or modify any of these provisions to better serve the needs of both the patient and the practice.
7. You have the right to request restrictions in the use of your Protected Health Information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.
8. I authorize the following people to be able receive information regarding my medical condition:

_____Relationship_____

_____Relationship_____

_____Relationship_____

I_____, do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward unless revoked by me in writing.

SIGNATURE: _____ DATE:_____