HIPAA Privacy Notification

Consent for Use or Disclosures of Health Information

Our Pledge –

At Paramount Eye Care we are, and always have been, concerned regarding your privacy. Although this disclosure is required by law, we have always and will continue to respect your privacy and your wishes regarding your personal information**. If you would like a copy** of our entire notice of privacy practices please let us know.

Several legitimate reasons exist that we may need to disclose or share your health information:

- If communications with another health care provider or hospital are needed for additional diagnosis, assessment, or treatment of your visual or systemic health.
- If another party, including insurance companies is responsible for payment of the services rendered.
- We may use your information within Paramount Eye Care for quality control, educational and/or operational purposes.

Your rights to privacy include your ability to request that your health information is not shared with specific individuals, companies, or organizations. **IF** you request any restrictions please provide those requests in writing. Remember, we are bound to your restrictions only if they do not interfere with the above reasons.

You may, at anytime, revoke your disclosure consent to us. Should you make this request, it must be in writing. These requests are unable to be retroactive for information already shared. Please remember that insurance has the right to obtain records/information for any of your claims if contested.

By signing below you acknowledge: "I have read your consent policy and agree to its terms. I am also acknowledging that I can request a copy of this notice."

Appointment Reminders and Health Care Information

Implicit in this policy is your authorization that Paramount Eye Care may use your name, address, phone number and clinical records to contact you with appointment reminders, information regarding health concerns, product information, etc. If this contact is made by phone, and you are not available, a message will be left on your voice mail. By signing this form, you are authorizing Paramount Eye Care to contact you by phone, email, mail, or fax for these reminders and/or information. This may also include sending your glasses or contact lens prescription to you via email/fax with your verbal confirmation.

______________________________ ________________________________

Patient Name (printed) Date

______________________________ ________________________________

Signature Authorized representative

Would you like an enhanced retinal screening with Optomap today? Yes No