PATIENT RIGHT TO PRIVACY

We at Athens Eye Care Center, P.C. respect your right to privacy. Therefore, we will only access and use your Protected Health Information (PHI) for treatment, payment, and healthcare operations such as:

1. To provide your care here in our office
2. To collect payment from your insurance company
3. To assist your pharmacy in filling your prescriptions
4. To coordinate care with another physician. Your records will be sent to any physician that we refer you to.

All other releases of your personal information will only be with your permission and authorized by a signature from you. **THIS INCLUDES YOUR IMMEDIATE FAMILY UNLESS OTHERWISE DESIGNATED BELOW.** You have the right to review or request copies of your records at any time. We request a 48 hour notice to allow us to accommodate you. In the event of an emergency, we will contact your designated emergency contact.

I authorize the staff of **Athens Eye Care Center, P.C.** to discuss my care with the following persons:

Name_______________________________ Relation _________________________
Name_______________________________ Relation _________________________

Notice to Parents/Guardians: According to federal policy, when a minor reaches the age of fourteen, we can no longer discuss the child's private medical information with a parent without the child present or a written consent from the child. The exception is as follows: if a child seeks medical treatment and whishes to use the parent's insurance policy. It is the policy holder's right to know what their insurance company has been billed for. If the child does not wish for the policy holder to be given that information, they must pay the office fee in full before services are rendered.

Please choose one:
I have a copy and have read the Privacy Policy __________
I have read but do not want a copy of the Privacy Policy __________
I have not read & do not want a copy of the Privacy Policy__________

I understand and consent to the use of my protected health information for the above purposes.

Signature ____________________________________ **Date** ____________________