Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Your point of contact about your rights to access your Health Records or complaints and comments about your health record privacy is:
TSO HIPAA Director
21019 US Hwy 281 N
Suite 832
San Antonio, TX 78258
You may file a complaint with the Director of HHS. We will use your Protected Health Information to provide appointment reminders, describe or recommend treatment alternatives and provide information about health related benefits and services that may be of interest to you. We will maintain the privacy of your health records, provide this Notice to you, abide by the terms of this Notice and reserve the right to revise the privacy practices of this office. You have the right to review or to copy your health records, request changes or offer amendments to your records, obtain a accounting of to whom we have disclosed information from your records and request restrictions on certain uses and disclosures from your health records. You also have the right to revoke our ability to disclose your health information by providing the practice with a signed written request. Until such a request is received, this Notice will be in effect for six years from the date of the most recently signed Notice.

I have received a copy of Texas State Optical **Notice Of Privacy Practices** with an effective date of April 2, 2010.

X ____ ____________________

SIGNATURE OF PATIENT (Or parent or guardian of a minor) DATE

Please list any family members and their relationship to you or others we may inform about your medical condition and diagnosis. ____

____.

In an emergency are there others we may contact about your medical condition?________________

____

Please print the address if you want to use an address other than your home address for receiving correspondence.____.

Please print the phone numbers you wish to receive calls regarding your health information.________

____.

Can we leave confidential messages on your home answering machine or voicemail? YES____NO_____.

Can a confidential message be left at your place of employment? YES______NO_____.

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(Patient Name) (Patient Signature or Representative Signature) (Representative Description) (Date)