

Moyes Eye Center
HIPAA PATIENT NOTICE

HIPAA is an acronym for the Health Insurance Portability & Accountability Act of 1996 (a federal law). Of significant concern to healthcare organizations is the Administrative Simplification section of the Act, which requires healthcare organizations to comply with specific rules regarding:

- Unique Identifiers for health plans, providers, individuals, employers
- Healthcare Transaction & Code Sets for transmitting data electronically
- Privacy regulations over disclosure and use of health information
- Security regulations over protections of electronic health information

It is our policy to not release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, cell phone and/or pager. Whenever returning phone calls and the answering machine picks up, we do not leave a message if the name or the telephone number is not on the recorded message to identify the residence. Information will also not be left with an unauthorized person who may answer the telephone. If you would like information released to someone other than yourself please complete the following:

I authorize Moyes Eye Center to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever the information changes.

Home telephone	yes _____	no _____
Answering machine	yes _____	no _____
Work telephone	yes _____	no _____
Voice mail	yes _____	no _____
Cell phone and/or voice mail	yes _____	no _____
Pager	yes _____	no _____
Can we fax medical records for referrals?	yes _____	no _____

Please list names of people we can discuss your medical care with:

Spouse: _____ yes _____ no _____

Parent: _____ yes _____ no _____

Other: _____

Please give name and relationship such as boyfriend, sister, etc.

Signature Patient/Guardian

Date

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of Moyes Eye Center Notice of Privacy Practices.
Patient Name

I, _____, refuse to accept a copy of Moyes Eye Center Notice of Privacy Practices.
Patient Name

Signature of Patient

Date