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 ACKNOWLEGEMENT 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

Patient Name _____

DOB _____

_____
Signature of Patient Date