Doctors For Visual Freedom

TO OUR PATIENTS: We are required by Federal Law entitled "Health Insurance Portability and Accountability Act" to present you with the following form for your review and signature:

With patient consent, Doctors For Visual Freedom Laser Center may use and disclose protected health information to carry out treatment, payment, and healthcare operations only. This includes, but is not limited to:

- appointment reminder calls to your home
- mailing information to your home regarding our practice
- calling and faxing prescription authorization to your pharmacist

Certain practices are NOT approved uses for your protected health information and will not ever be performed. This includes:

- Selling your information to any third parties for marketing purposes
- releasing your information for any purposes without your signed consent

To help us protect your health information, we will maintain a copy of your driver's license or state identification card with your signature on file. If you wish, you do have the right to review the Notice of Privacy Practices prior to signing this consent. You will likely be seeing this notice, or ones similar to it, at other health care facilities. Doctors For Visual Freedom Laser Center reserves the right to revise its Notice of Privacy Practices at any time, within the parameters of HIPAA. A revised Notice of Privacy Practices may be obtained by sending a written request to the Doctors For Visual Freedom Laser Center Privacy Officer.

You have the right to review your medical records and make amendments to those records. Records may be obtained by sending a written request to the Doctors For Visual Freedom Laser Center Privacy Officer.

You have the right to submit a written request that Doctors For Visual Freedom Laser Center restricts how it uses or discloses your protected health information.

You may revoke this consent in writing except to the extent that the practice has already made disclosures with this prior consent.

By signing below you are also authorizing Dr. Mark Golden and/or personnel from Doctors For Visual Freedom to provide your first and last name to personnel at the main desk in The John Hancock Center for the sole purpose of authorizing your entrance to the building and allowing access to the elevators so that you may go to suite 1550, where the office for Doctors For Visual Freedom is located.

Please circle:

YES NO Doctors For Visual Freedom Laser Center may call my home, or another designated number and leave a message, recorded or with a person, regarding items that assist the practice in carrying out treatment, payment, and operations.

YES NO Doctors For Visual Freedom Laser Center may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment, and operations.

YES NO Doctors For Visual Freedom Laser Center may email to my home or other designated location any items that assist the practice in carrying out treatment, payment, and operations.

YES NO Doctors For Visual Freedom Laser Center may text message my cell phone with any items that assist the practice in carrying out treatment, payment, and operations.

Patient Name _____Date of Birth _____

Signature_____Date_____