**Bixler Eye Care**

HIPAA/PRIVACY PATIENT CONSENT FORM

*This notice describes how medical information about you may be used and disclosed. It also describes how you can get access to this information. Please review this notice carefully.*

We provide this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). The notice contains a Patient Rights section describing your rights under the law. You have the right to review our notice before signing this consent.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations, and/or as required by law. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in compliance with your prior Consent.

Bixler Eye Care has the right to change their Privacy Practice Notice at any time. If Bixler Eye Care changes their Notice, the new Privacy Practice Notice will apply to all health information that they already have as well as any information we receive in the future. If we change our Notice, we will notify you at your next appointment and you may obtain a revised copy by contacting our office.

Your signature on this form will give us the right to phone, email, or send a text to you to confirm appointments. We may leave a message on your answering machine at home or on your cell phone.

A more complete description of your rights and our notice of privacy practices are available by the reception desk in our office. My signature below verifies that I have read and agreed to the conditions of this consent form.

Patient’s Name (please print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Authorized Agent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_

Relationship, if other than patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_