DRUMMOND EYE CLINIC

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT AND CONSENT OF PRIVACY POLICIES

The Notice of Privacy Practices explains in detail how we may use and share your health records. **Please read it.**

- We will use and share your health records to treat you.
- We will use and share your health records to bill for the services we provide.
- We will use and share your health records to operate the business.
- We will use and share your health records as required by law.

The Notice of Privacy Practices also explains in detail the following rights you have with respect to your health records.

- You have the right to look at and receive a copy of your health records.
- You have the right to receive a list of whom we have given your health records to.
- You have the right to ask us to correct a mistake in your health records.
- You have the right to ask that we not use or share your health records.
- You have the right to ask us to change the way we contact you.

Oklahoma law requires that we advise you that **the information authorized for disclosure may include information which may be considered a communicable or venereal disease, including, but not limited to, Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (AIDS).** It also may include mental health or other sensitive information.

If you would like the physicians and staff of Drummond Eye Clinic to be able to discuss your health record with any other individuals (including diagnoses, treatments, dates and times of surgeries, etc.) you must give permission for them to access your Protected Health Information (PHI).

PLEASE LIST ANY INDIVIDUALS YOU WOULD LIKE TO HAVE ACCESS TO YOUR HEALTH RECORD BELOW:

Name: ____ Relationship to Patient: ___________________________

Name: ____ Relationship to Patient: ___________________________

Name: ____ Relationship to Patient: ___________________________

ACKNOWLEDGEMENT

I have received and reviewed a copy of the Drummond Eye Clinic's Notice of Privacy Practices.

PATIENT / LEGAL REPRESENTATIVE SIGNATURE: _____________________________________ DATE: _____________

Capacity of Legal Representative (if applicable): ____________________________

May be requested to provide verification of representative status.

CONSENT

I consent to the use and sharing of my health records for treatment, payment and operation purposes as described in the Notice of Privacy Practices. <u>I understand that if I do not consent, you cannot provide services to me.</u>

I give permission to the physicians and staff of Drummond Eye Clinic to share Protected Health Information (PHI) with the individuals listed above.

PATIENT / LEGAL REPRESENTATIVE SIGNATURE: _____________________________________ DATE: _____________

Capacity of Legal Representative (if applicable): ____________________________

May be requested to provide verification of representative status.