GOOD EYE
OPTOMETRY

HIPAA PRIVACY POLICY

We provide this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Good Eye Optometry Inc will maintain the privacy of your health information and personal data. Your information will only be released upon your authorization.

By signing this form:

____ I **consent** to Good Eye Optometry Inc.'s use and disclosure of protected health information about me for treatment, payment and health care operations, and/or as required by law.

____ I **authorize** any holder of medical information to be released and/or to request my medical information from other health care professionals for the purpose of consultation and referral as appropriate for my individual heath care needs.

____ I **authorize** any holder of medical information to be released to workers' compensation insurances, medical service companies and auditors.

____ I **authorize** Good Eye Optometry Inc to contact me by telephone including text messages and other media devices for communication to monitor progress and/or recommended care.

____ I **authorize** any holder of medical information about me to be released to my insurance company or its agent any information needed to determine these benefits payable for related services. I request that payment of authorized services be made on my behalf to Good Eye Optometry Inc.

The doctors and staff of Good Eye Optometry appreciate your compliance with these policies and procedures. We strive to provide the best eye care available to you. We are happy to discuss any questions or concerns you have about these policies.

_____ _____ _____

Printed Patient Name (and Guardian Name if applicable) Patient or Guardian Signature Date

I give permission to communicate my private healthcare Information to:

_____ _____

Name Relationship