PAMELA GOLCHET, MD
DIPLOMATE, AMERICAN BOARD OF OPHTHALMOLOGY
DISEASES OF THE RETINA & VITREOUS

HIPAA Acknowledgment Form

Treatment, Payment, or Healthcare Operations:

I ___________________________, understand that as part of my healthcare, *Visionary Retina Center* originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Privacy Policies* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations.

I understand that *Visionary Retina Center* is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that *Visionary Retina Center* reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.506 of the Code of Federal Regulations. Should *Visionary Retina Center* change their notice, they will send a copy of any revised notice to the address I have provided (whether U.S. mail or, if I agree, e-mail).

HIPAA: I have been made aware of the privacy policies of *Visionary Retina Center* and understand that if I should choose to make any changes to this information that it is my responsibility to notify the office immediately.

I fully understand and accept the terms of this consent.

___________________________	___________
SIGNATURE – Patient or Patient's Authorized Representative	DATE
___________________________	___________
PRINT NAME - Patient or Patient's Authorized Representative	Relationship to Patient
___________________________	___________
Witness – Name and Signature	DATE