Patient Acknowledgement

Notice of Privacy Practices

Our *Notice of Privacy Practices* describes in detail how your health information may be used and disclosed, and how you can access your information.

By signing below, you acknowledge that you have received a copy of the *Notice of Privacy Practices* of Carol Logan, O.D., and Logan Eye Care.

_____ _____

Patient or legally authorized individual signature Date

_____

Printed name if signed on behalf of the patient

Consent of Disclosure

For Health Information For Treatment, Payment, and Health Care Operations

During the course of providing service to you, we create, receive, and store health information that identifies you. As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to safeguard your confidentiality. It is often necessary to use and disclose your health information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office. When it is appropriate and necessary, we provide the minimum necessary information to only those in need of your health care information.

When you sign this consent document, you acknowledge and authorize that we may disclose your health information for treatment, payment for our services, and to perform health care operations that includes:

- The use and disclosure of your health information for treatment purposes, not only includes care and services provided here, but also disclosures of your health information, as may be necessary for you to receive follow-up care from us or another health professional.
- The use and disclosure of your health information for the purposes of payment, including, but not limited to, providing this information to your insurance company, third party, billing agent or other vendor for eligibility, determination of benefits, processing claims and receiving payment.
- We may have indirect treatment relationships with other organizations (such as laboratories and vendors) and may have to disclose personal health information for purposes of treatment, payment, or health care operations.
- That support personnel employed by this professional practice or any affiliated agencies, vendors or companies, including the optical personnel will have access to your health information.
- The payment of medical insurance benefits to Carol Logan, O.D., and Logan Eye Care, or other appointed agencies or parties who may accept assignment for services provided.

You have the right to restrict or revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI).

By signing below, you acknowledge that you have read and understand that above information and voluntarily consent to the statements herein.

_____ _____

Patient or legally authorized individual signature Date

_____

Printed name if signed on behalf of the patient