



Patient Authorization Form for Use and Disclosure of Protected Health Information

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operation.

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 protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest. We provide for you a copy of our Statement of Patients' Rights and our Privacy Notice and, upon request, you may schedule a time to review our entire plan for privacy compliance. The notice you are given is a summary of this comprehensive plan.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse disclosure of your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse disclosure of all or part of your PHI. You may not revoke actions that have already been taken which relied on this or previously signed consent.



Your signature on this document indicates that you agree to allow the disclosures used in the context stated above in the routine business of treatment, payment, or health care operations.

Please initial: _____ I have received a copy of "HIPAA Notice of Privacy Rights" and "Statement of Patients' Rights" and "Patients' Responsibilities" brochure.

PRINT NAME: _____ SIGNATURE: _____ DATE: _____

Mecklenburg Eye Associates, P.A.

Date: _____

To Our Patients: On this date, you have received copies of our documents that summarize our pledge to protect the privacy of your Personal Health Information. The physicians and staff of Mecklenburg Eye Associates, P.A. have received training to understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule" and we will continue to keep current with these regulations. We strive to achieve the very highest standards of ethics and integrity in performing services for our patients. We will provide appropriate security for our patient records. We will protect the privacy of our patients' medical information. We will provide our patients with proper access to their medical records and will appropriately maintain our patient information and billing processes in compliance with national standards. If you have any questions regarding our policies, please contact our Compliance officer!

Thank you for being one of our highly valued patients.