PRIVACY ACT NOTICE FOR PATIENT
Use and Disclosure of Protected Health Information

Please note, our *Notice of Privacy Practices* policy, is available at the front desk, Visionary Ophthalmology, doing business as Visionary Eye Doctors, and also online at our website, www.voeyedr.com. This *Notice of Privacy Practices* provides detailed information about how we may use and disclose protected health information about you. The details of this policy are in full compliance with all provisions, including those most recently updated.

Acknowledgement & Consent Form for Use and Disclosure of Information

Copies of our *Notice of Privacy Practices* provides information about how we may use and disclose protected health information about you, and is compliant with the requirements of the *Health Insurance Portability and Accountability Act of 1996 (HIPAA*). Our *Notice of Privacy Practices* states that we reserve the right to change terms described. Should this happen, we will display the new policy and effective date in our office. You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree with your restrictions; but if we do, we are bound by our agreement with you. By signing below, I acknowledge receipt of the *Notice of Privacy Practices* and give my full consent to Visionary Ophthalmology, doing business as Visionary Eye Doctors, to the use and disclosure of protected health information about me for treatment, payment, and health care operations. I have the right to revoke this consent, in writing, except where the practice has already made disclosures in trust on my prior consent. If you have any questions please call us at **301-896-0890.**

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Patient/Responsible Party Signature **Date**

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Patient/Responsible Party Printed **Date**

Personal Representative, Family or Other Entities Authorized Access to Protected Health Information to be Used and/or Disclosed

Name or specifically identify these persons and/or other entities you are authorizing to make use of and/or to disclose your protected health information regarding treatment, payment and other healthcare operations.

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Name of Authorized Person or Entity **Relationship** **Phone number**

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