Jeffrey D. Horn, MD
VISION FOR LIFE

HIPAA ACKNOWLEDGEMENT FORM

I am a patient of Vision for Life. I hereby acknowledge receipt of Vision for Life's Notice of Privacy Practices (attached).

Name (please print): _____

Email Address: _____

Cell Phone: _____

Signature: _____

Date: _____

OR

I am a legal guardian of _____ (patient name).
I hereby acknowledge receipt of Vision for Life's Notice of Privacy Practices with respect to this patient.

Name (please print): _____

Relationship: ☐ **Parent** ☐ **Legal Guardian**

Email Address: _____

Cell Phone: _____

Signature: _____

Date: _____

By signing the above you agree to receive educational and marketing materials from Vision for Life. You also agree that your name and/or image may be used as an endorsement for services from Vision For Life in media education, advertising, and public relations. For more information on Vision For Life's privacy policy, please visit https://visionforlife.com/privacy-policy/. If you would like to opt out of Vision for Life's educational and marketing materials please fill out the below.

Name (please print): _____

Signature: _____

PATIENT COMMUNICATION FORM

Family and Friends. It is the office policy of Vision for Life not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment, (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers, please indicate that below, so that we may best serve you. If you do not want any of your medical information provided to a family member, please check (√) the line next to the "no" response. By signing below, you authorize the following people to receive information regarding your treatment or care. (If you wish to add names later on, please confirm this in writing, or call our staff.)

Spouse: _____ **Phone:** _____ ☐ **YES** ☐ **NO**

Parent: _____ **Phone:** _____ ☐ **YES** ☐ **NO**

Other: _____ **Phone:** _____ ☐ **YES** ☐ **NO**

FOR OFFICE USE:

Changes to above authorized by patient over phone:

Change: _____ **Date:** _____ **Staff Initials:** _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE READ IT CAREFULLY

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your personal health information (PHI) is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operation.

- Treatment means providing, coordinating, or managing healthcare and related services by one or more healthcare providers. An example of this would include referring you to a specialist.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be patient survey cards or notifying you of practice services.
- The practice may also disclose your PHI for law enforcement and other legitimate reasons although we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you by phone, text, email or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and healthcare operations;
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You may have the following rights with respect to your PHI:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services, "out of pocket", in full and you request that we not disclose, to a health plan, those services, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your Protected Health Information and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice is effective as of today's date, and it is our intention to abide by the terms of the notice of Privacy Practices ad HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practices from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with our office and with the Department of Health and Human Services, Office of Civil Rights, without fear of retaliation for filing a complaint.