ADVANCED RETINA ASSOCIATES
1053 MEDICAL CENTER DRIVE, SUITE 251
ORANGE CITY, FL 32763
(386) 456-0210

HIPAA PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payors

Conduct normal healthcare operations, such as quality assessments and physician certifications

I have been informed by you of your Notice Of Privacy Practices, containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice Of Privacy Practices and have received a copy of the Patient's Notice of Privacy Practices. I understand that this organization has the right to change its Notice Of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice Of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions.

Printed Patient Name _____

Signature _____

Witness _____

Date _____