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HIPAA Privacy Form

Consent for Purposes of Treatment, Payment, and Healthcare Operations
Authorization for Use or Disclosure of PHI

I consent to the use or disclosure of my protected health information by Cataract and Cornea Eye Specialists, LLC for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Cataract and Cornea Eye Specialists, LLC.

I have the right to revoke this consent, in writing, at any time, except to the extent that Anita Hwang, M.D. or Cataract and Cornea Eye Specialists, LLC has taken action in reliance on this consent.

My “Protected Health Information” (PHI) means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This PHI relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I also authorize Cataract and Cornea Eye Specialists, LLC to use and/or disclose information about myself to the following identifiable individuals:

Spouse: ________________________ Partner: _______________________ Parent: ______________________

Family Member: ________________________________ Other: _____________________________________

You may ___ / may not ___ leave me a message on my answering machine or voicemail.

You may ___ / may not ___ contact me via cell phone.

You may ___ / may not ___ contact me at my work place.

Acknowledgement of Receipt of Notice of Privacy Practices

I, ________________________________, have read / do not want to read an office copy of Cataract and Cornea Eye Specialists’ Notice of Privacy Practices.

____ ___________________________________

Signature of Patient or Personal Representative | Date

____ ___________________________________

Print Name of Patient or Personal Representative | Description of Representative’s Authority