

Health Insurance Portability and Accountability Act (HIPAA)
Compliance Patient Consent Form

Our Notice of Privacy Practices, required by HIPAA, provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. Your signature confirms that you have had the opportunity to review our notice before signing this consent. The terms of the notice may change; if so, you will be notified at your next visit to update your signature/date.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The patient has the right to request a restriction on the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time.
- The practice may require this form to be fully executed in order to offer treatment.

My signature confirms that I have read this information and I understand my rights under HIPAA.

Patient Name / Guardian

Date

Patient / Guardian Signature

Health Insurance Portability and Accountability Act (HIPAA) - Email Consent

Please be aware that although the information stored on our computers is encrypted, most popular email services do not utilize encrypted email. This means that when we send you an email, or you send us an email, the information is not encrypted. Without encryption, a third party may be able to access the information and read it. Once an email is received by you, it can be accessed by outside parties and read.

The federal government has provided guidance on email and HIPAA on the U.S. Department of Health and Human Services website: <http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf>

The guidelines state that if a patient has been made aware of the risks of unencrypted email, and that the same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email.

I understand the risks of unencrypted email and do hereby give permission to Wills Eye, to include the specialty services, to send me personal health information via unencrypted email.

I have read, understand and will comply with the information contained within this email policy.

Patient Name / Guardian / Agent

Date

Patient / Guardian / Agent Signature

Relationship