Patient Name _____

PRIVACY POLICY CONSENT

Federal Law required that all patients be given a copy of the Eye Consultants of Rhode Island *Notice of Privacy Practices*. This *Notice* describes in detail how patient health information is used and shared with others. You have the right to review our Notice prior to sign this consent. Eye Consultants of Rhode Island reserves the right to change the *Notice of Privacy Practices* at any time.

All reasonable efforts will be made to protect the privacy of patient healthcare information, whether it is maintained on paper or electronically and regardless of how the method used for communicating it.

In accordance with the privacy standards issued by the United States Department of Health and Human Services, pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I hereby consent to Eye Consultants of Rhode Island using and disclosing my protected health care information for the purposes of treatment, billing, and health care operations.

_____ Date: _____
Patient Signature

CONFIDENTIALITY RELEASE

Many of our patients allow family members such as their spouse, significant other, parents, or children to call and request the results of tests, procedures, and financial information. Under the requirements for HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test result, and/or any financial information released to any family members you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Eye Consultants of Rhode Island, Ltd. to release my records and any information requested to the following individuals

Name: _____ Relationship: _____

Phone Number: _____ Alternate Number: _____
Is this person your Power of Attorney for medical purposes? □ Yes □ No

Name: _____ Relationship: _____

Phone Number: _____ Alternate Number: _____

_____ Date: _____
Patient Signature