WOLF EYE CENTER, INC.

NOTICE OF PRIVACY PRACTICES

Patient Name:_____ **Chart #:**_____

Our Notice of Privacy Practices provides information about how we may use and disclose Protected Health Information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how Protected Health Information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, except in certain limited instances, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of Protected Health Information about you for non-subsidized treatment, payment and health care operations, and for other purposes as permitted or required by law. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected Health Information may be disclosed or used for treatment, payment or health care operations, or for other purposes permitted or required by law. However, we will obtain from you a separate written authorization for "subsidized" disclosures, meaning disclosures involving product or service with respect to which the Practice receives remuneration from a third party.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions, except in certain limited instances.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

This Consent was signed by: _____
Patient or Representative

Relationship to Patient (if other than patient):_____

Date:_____

In front of _____
Printed name – Practice representative

WOLF EYE CENTER, INC.

PATIENT COMMUNICATION FORM

Patient Name:_________________________________ **Chart #:**_______________

A. Family and Friends. It is the office policy of Wolf Eye Center not to release confidential medical information regarding your treatment to family members or friends, except for (1.) parent/legal guardian, (2.) other persons authorized by the patient, (3.) 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), (4.) in emergency situations, or (5.) 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/babysitters, 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: __________________________________ _______ yes _______ no

Parent: __________________________________ _______ yes _______ no

Other: __________________________________ _______ yes _______ no

__________________________________ _______ yes _______ no

__________________________________ _______ yes _______ no

B. Alternative Communications. You are also entitled to specify alternative, reasonable means of communication, if you do not wish to be contacted by us in a certain way. We currently contact patients by phone, text and email.

I hereby request Wolf Eye Center does NOT contact me by:_____________________________

Printed Name: ____

Patient/Parent/Guardian Signature:____

Date: _____________________________

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FOR OFFICE USE

Changes to above authorized by patient over phone:

Change	Date	Staff Initials
______________________________________	________	_______
______________________________________	________	_______
______________________________________	________	_______