HIPAA CONSENT FORM AND NOTICE OF PRIVACY PRACTICE POLICY

Kearney Eye and Grand Island Eye Institute is providing this consent to comply with the privacy regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

We understand that your medical information is personal to you and we are committed to protecting such information. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide you. By law, we are required to make sure that your protected health information is kept private.

This is a summary of the privacy practices at Kearney Eye and Grand Island Eye Institute. This serves as a condensed version of our notice of privacy practices. You have the right to review our entire notice before signing this consent. The terms of our notice may change and you may obtain a revised copy by contacting our office.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

How will we use or disclose your information? Here are a few examples:

- For vision, medical eye treatment & referral to another doctor/facility.
- To obtain payment & file insurance
- In emergency situations
- For appointments and patient recall reminders
- To run our Practice more efficiently and insure all our patients receive quality care
- For research and education
- To prevent serious threats to health safety
- For workers' compensation programs
- In response to certain requests arising out of lawsuits or other disputes

This also serves as an authorization under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996 [45 CFR § 164.508]. It authorizes Kearney Eye and Grand Island Eye Institute staff to use and/or disclose my protected health information (PHI) with the individual(s) I have listed below for the purpose(s) of administering my healthcare, financial information, appointment information, providing me with case management and other services as it deems appropriate. This authorization is valid until such time as I elect to revoke it.

Name of Person(s) being given consent to obtain PHI on patient:

Name:_____ Phone:_____

Relationship to Patient_____

Name:_____ Phone:_____

Relationship to Patient_____

Name:_____ Phone:_____

Relationship to Patient_____

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. Additionally, by signing this form, you acknowledge that by presenting yourself as a patient or parent/guardian of a child you consent for vision and medical eye care by the doctors and staff at Kearney Eye Institute.

Patients Name (Printed):_____ Patient Signature:_____

Guardians Name (Printed): _____ Guardians Signature:_____

Date: _____