Patient Name:	
Account No.:	
Date:	

HIPAA CONSENT

joey's optical
1645 North Central Avenue
Marshfield WI 54449
715-502-3464

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Permission to Use and Disclose My Health Information: By signing this form, I give joey's optical permission to use and/or disclose my health information to provide treatment, obtain payment, and/or conduct health care operations. Please list person/s:

_____

_____

Right to Refuse: I have the right not to sign this consent. If I refuse to sign this consent, joey's optical has the right to refuse to treat me. However, treatment required by law – such as emergency care– can be provided to me whether or not I sign this consent.

Right to Review Notice of Privacy Practices: I have been provided with a copy of the Notice of Privacy Practices for joey's optical which describes how joey's optical may use and disclose my health information. I have the right to review this Notice before signing this consent.

Changes to the Notice of Privacy Practices: joey's optical may change the Notice of Privacy Practices as needed. I may obtain a current copy of the Notice of Privacy Practices for joey's optical by contacting joey's optical.

Right to Request Restrictions on Use/Disclosure: I have the right to request that the usage of my protected health information by joey's optical be restricted in how it is used and/or disclosed for the purpose of providing treatment, obtaining payment, and/or conducting health care operations. However, joey's optical is not required to agree to any restriction that I request. If joey's optical does decide to agree to my request, the use and/or disclosure of my health information by joey's optical must be restricted as I requested. If I wish to request restrictions I can contact joey's optical. Joey's optical will notify me on whether my restrictions have been accepted or declined.

Right to Withdraw Consent: I have the right to withdraw this consent at any time. I must do so in writing by contacting joey's optical at 1645 N Central Ave, Marshfield, WI 54449. My withdrawal of this consent will not be effective for uses and/or disclosures that have already been made based on my prior consent. If I withdraw this consent, then joey's optical may refuse to provide to me further treatment or follow-up, other than required emergency services.

Effective Period: This consent is good unless and until I withdraw it in writing.

References to "I" or "me": References to "I" or "me" in this Consent include the individual for whom the signing party is authorized to sign. If I am signing this consent on behalf of another person, it is because I am that person's parent, legal guardian, or agent under an active Power of Attorney for Health Care; and I am legally authorized to sign this Consent on behalf of that person.

_____

_____

Signature of patient or authorized representative
Date
Name of Patient:

_____

_____

Authorized representative's name

FOR OFFICE USE ONLY

Complete this section if this form is not signed and dated by the patient or an authorized representative for the patient.

I have made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices for joey's optical but was unable to for the following reason:

- ❑ Patient refused to sign
- ❑ Patient is unable to sign
- ❑ Other _____

_____
_____
Signature of employee Date

_____
_____
Employee's name