# HIPAA PRIVACY PRACTICES

I understand that Achieve Vision Center will use and disclose health information (also known as PHI or Protected Health Information) about me in accordance with the laws and regulations governing such usage.

I understand that this health information may include information created and received by the practice, may be in the form of written or electronic records, or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information. I understand that this practice may use and disclose my health information, in accordance with federal law, without my express consent, in order to:

* Make decisions about and plan for my care and treatment;
* Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment; and
* Perform various office, administrative, and business functions that support my doctor’s efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how Achieve Vision Center will handle health information about me. This written description is known as the Notice of Privacy Practices which describes the uses and disclosures of health information, how those disclosures are made, the practices followed by the employees, staff, and other office personnel and my rights regarding my health information and how it is used, disclosed and protected.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that the copy or a summary of the most current version of the Notice of Privacy Practices in effect will be available at any time and is posted in the office for review.

I understand that I have the right to ask that some or all my health information not be used or disclosed in the manner described in the Notice of Privacy Practices. I understand that Achieve Vision Center is not required by law to agree to such requests. I also understand that any questions, issues or concerns that I may have regarding how my information is maintained or used should be directed to the Achieve Vision Center Privacy Officer 770-509-2232.

**By signing below, I agree that I have reviewed and understand the information above and that I have received or have been offered a copy of the Notice of Privacy Practices.**

By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Patient or Patient Representative Signature)

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If Patient Representative, relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# RELEASE OF INFORMATION

**IT IS OFTEN BENEFICIAL TO US TO DISCUSS EXAMINATION RESULTS AND TO**  **EXCHANGE INFORMATION WITH YOUR CHILD’S SCHOOL AND/OR OTHER PROFESSIONALS INVOLVED IN HIS/HER CARE. PLEASE SIGN BELOW TO AUTHORIZE THIS EXCHANGE OF INFORMATION.**

I agree to permit information from, or copies of, my child’s examination records to be forwarded to my child’s school and other health care providers upon their written request or upon the recommendation of Achieve Vision Center when it is necessary for the treatment of my child’s visual condition. I authorize **Normanie M. Ricks, MS OTR/L** and **Achieve Vision Center** to exchange information with my child’s school and other professionals involved in my child’s care, by means of my signature below. This authorization shall be considered valid throughout the duration of treatment.

By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Patient or Patient Representative Signature)

If Patient Representative, relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# PERMISSION TO TREAT

I hereby give my permission to Achieve Vision Center to treat:

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This authorization is valid for the duration of treatment. Thank you for carefully completing this questionnaire. The information supplied will allow for a more efficient use of time and will enable us to perform a more comprehensive evaluation of your child and to better meet your child’s specific visual needs.

By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Patient or Patient Representative Signature)

If Patient Representative, relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_