Olympia Vision Clinic
1625 Cooper Point Rd SW
Olympia, WA 98502
O: (360) 357-668 F: (360) 754-0482

Olympia Vision Clinic
5210 Corporate Center Court SE, Ste A
Lacey, WA 98503
O: (360) 459-2108 F: (360) 459-2875

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- ❖ **Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.**
- ❖ **Obtain payment from third-party payers.**
- ❖ **Conduct normal healthcare operations such as quality assessments and physician certifications.**

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: ____

Signature: ____

Relationship to Patient: ____________________________________

Date: ________________

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I hereby authorize___________________________**to obtain my medical information.**

How is this person related to you?_______________________________________

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but written acknowledgement could not be obtained because:

- ☐ **Individual refused to sign**
- ☐ **Communication barriers prohibited obtaining written acknowledgements**
- ☐ **An emergency situation prevented us from obtaining acknowledgement**
- ☐ **Other (please Specify)**

____ ______________________________

Signature **Date**

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

NOTICE OF PRIVACY PRACTICES

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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.

GENERAL RULE

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give notice of our privacy practices.

Generally, we cannot use your health information in our office or disclose it outside of our office without your written permission. Sometimes the written permission will be called a consent form, and sometimes it will be called an authorization form. The type of permission form will depend upon the kinds of uses or disclosures that are involved. In some limited situations, the law allows or requires us to disclose your health information without either a written consent or authorization.

USES OR DISCLOSURES WITH CONSENT

We will ask you to sign a consent form allowing us to use and disclose your health information for purposes of treatment, payment, and health care operations of this office. We are allowed to refuse to treat you if you do not sign the consent form.

We use information for treatment purposes, when, for example, we set up an appointment for you, when our technician or doctor tests your eyes, when the doctor prescribes glasses or contact lenses, when you doctor prescribes medication, when our staff helps you select and order glasses or contact lenses, and when we show you low vision aids. We may disclose your health information outside of our office for treatment purposes if we, for example; refer you to another doctor or clinic for eye care or low vision aids or services, if we send a prescription for glasses or contacts to another to be filled, when we provide a prescription for medication to a pharmacist, or when we phone to let you know that your glasses or contact lenses are ready to be picked up. Sometimes we may ask for copies of your health information from another professional that you may have seen before us.

We use your health information for payment purposes when, for example, our staff asks you about health or vision care plans that you may belong to, or about other sources of payment for our services, when we prepare bills to send to you or your health or vision care plan, when we process payment by credit card, and when we try to collect unpaid amounts due. We may disclose your health information outside of our office for payment purposes when, for example, bills or claims for payment are mailed, faxed, or sent by computer to you or your health or vision plan, or when we occasionally have to ask a collection agency or attorney to help us with unpaid amounts due.

We use and disclose your health information for health care operations in a number of ways. Health care operations mean those administrative and managerial functions that we have to do in order to run our office. We may use or disclose your health information, for example, for financial or billing audits, for internal quality assurance, for personnel decisions, to enable our doctors to participate in managed care plans, for the defense of legal manners to develop business plans, and for outside storage of our records.

USES AND DISCLOSURES WITHOUT CONSENT OR AUTHORIZATION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose;
- For public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the Food and Drug Administration regarding drugs or medical devices;
- Disclosures to governmental authorities about victims of suspected abuse, neglect, or domestic violence;
- Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim f a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- Uses or disclosures for health related research;
- Uses and disclosures to prevent a serious threat to health or safety;
- Uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- Disclosures relating to worker's compensation programs;
- Disclosure to business associates who perform health care operations for us and who agree to keep your health information private.

APPOINTMENT REMINDERS

We may call to remind you of scheduled appointments. We may also call to notify you of other treatments or services available at our office that might help you.

OTHER DISCLOSURES

We will not make any uses or disclosures of your health information unless you sign a written authorization form. You do not have to sign such a form. If you sign one, you may revoke it at any time unless we have already acted in reliance upon it.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operation. We do not have to agree to do this, but if we agree, we must honor the restriction that you want. To ask for a restriction, send a written request to Dr. Dale Tosland, Dr. Joanna Haws, Dr. Mary Ferris, Dr. R. Trent Cluny, Dr. Angela Loeb, Dr. Jeremy Whitney or Dr. Derek Sturtevant at the address or fax shown at the beginning of this Notice.
- Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using e-mail to your personal e-mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to Dr. Dale Tosland, Dr. Joanna Haws, Dr. Mary Ferris, Dr. R. Trent Cluny, Dr. Angela Loeb, Dr. Jeremy Whitney or Dr. Derek Sturtevant at the address or fax shown at the beginning of this Notice.

- Ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part,

however, you will be able to review or have a copy of your health information within 30 days of asking us. You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation and instructions about how to get an impartial review of our denial if one is legally required. By law, we can have one 30-day extension of the time for us to give you access or photocopies if we send you a written notice. If you would like to obtain this information, send a written request to Dr. Dale Tosland, Dr. Joanna Haws, Dr. Mary Ferris, Dr. R. Trent Cluny, Dr. Angela Loeb, Dr. Jeremy Whitney or Dr. Derek Sturtevant at the address or fax shown at the beginning of this Notice.

- Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30-day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request including your reasons for the amendment to Dr. Dale Tosland, Dr. Joanna Haws, Dr. Mary Ferris, Dr. R. Trent Cluny, Dr. Angela Loeb, Dr. Jeremy Whitney or Dr. Derek Sturtevant at the address or fax shown at the beginning of this Notice.
- Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want), except disclosures for purposes of treatment, payment, or health care operations and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30-days extension for time if we notify you of the extension in writing. If you want a list, send a written request to Dr. Dale Tosland, Dr. Joanna Haws, Dr. Mary Ferris, Dr. R. Trent Cluny, Dr. Angela Loeb, Dr. Jeremy Whitney or Dr. Derek Sturtevant at the address or fax shown at the beginning of this Notice.
- Get additional paper copies of this Notice of Privacy Practices upon request; no matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to Dr. Dale Tosland, Dr. Joanna Haws, Dr. Mary Ferris, Dr. R. Trent Cluny, Dr. Angela Loeb, Dr. Jeremy Whitney or Dr. Derek Sturtevant at the address or fax shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time in compliance with and as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice for Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web Site.

COMPLAINTS

If you think what we have not properly respected the privacy of your health information, you are free to complain to us or to the U.S. Department of Health and Human services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written message to Dr. Dale Tosland, Dr. Joanna Haws, Dr. Mary Ferris, Dr. R. Trent Cluny, Dr. Angela Loeb, Dr. Jeremy Whitney or Dr. Derek Sturtevant at the address or fax shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit Olympia Vision Clinic at the address or phone number shown at the beginning of the Notice.