HIPAA ACKNOWLEDGMENT AND CONSENT FORM

Hope Eye Center, PLLC

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize Hope Eye Center to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of this practice, Hope Eye Center.

I have also been informed of and given the right to review and secure a copy of this practice's Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that Hope Eye Center reserves the right to change the terms of this notice from time to time and that I may contact this practice at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that Hope Eye Center is not required to agree to these requested restrictions. However, if this practice does agree, it is then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

I understand that I may contact the Privacy Officer (privacy@hopeeyecenter.com) designated on the Notice of Privacy Practice if I have a question or complaint. I understand that this information may be disclosed electronically by Hope Eye Center and/or its business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Notice of Privacy Practice.

Patient Signature: _____

Print Patient Name: _____

Date: _____

If patient is unable to sign:

Signature of patient's guardian or representative: _____

Relationship to patient: _____

Date: _____