Name:____________________________________

Date:______________________

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE READ CAREFULLY**

We are required by law to:

- make sure that medical information that identifies you is kept private.
- give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- follow the terms of the notice that is currently in effect.

For Treatment & Payment:

We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, insurance companies, attorneys, courts, or any other personnel who are involved in taking care of you as well as friend or family member. If you choose not to have information released to a particular individual, please indicate the name of the person below along with your signature.

______________________________________________________

______________________________________________________

________________________________ ____________________

Patient/Guardian Signature Date

Right to request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. This must be done in writing.

Appointment Reminder:

We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care.

Right to Inspect and Copy:

You have the right to inspect and copy medical information that may be used to make decisions about your care.

PLEASE COMPLETE THE SECOND PAGE

Right to Amend:

If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, your request must be in writing and forwarded to our office at 3333 Fairmont Avenue, Asbury Park, NJ 07712.

We may deny your request if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us
- Is not part of the medical information kept by our office
- Is not part of the information which you would be permitted to inspect and copy
- Is accurate and complete

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing. If we change our notice, you may obtain a revised copy.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

"I agree that The Eye Diagnostic and Surgery Center may request and use my prescription medication history from other healthcare providers or third party pharmacy payers for treatment purposes."

| Patient/Guardian Signature | Please Print Name | Date |
| --- | --- | --- |