KAYE EYECARE
OF HUNTLEY
See A World of Difference

12545 Farm Hill Dr.
Huntley, IL 60142
847-961-6800

HIPAA Privacy Consent Form

Patient Name:_____ DOB:_____

This consent form allows Kaye Eyecare of Huntley, Ltd. to use and disclose information about me protected under the Health Insurance Portability and Accounting Act of 1996. The information may be used or disclosed to carry out treatment, payment, or health care operations.

Kaye Eyecare of Huntley, Ltd. has provided me with a Notice of Privacy Practices which more completely describes such uses and disclosures. Kaye Eyecare of Huntley, Ltd. provided this notice prior to my signing this form in accordance with my right to review its practices before signing consent. I understand the terms of the Notice of Privacy Practices may change and that I may obtain revised notices by requesting a revised notice on any office visit.

I understand I have the right to request, now and in the future, how protected health information is used or disclosed to carry out treatment, payment, and health care operations. I understand that while Kaye Eyecare of Huntley, Ltd. is not required to agree to my request restriction, if it does agree, it is bound by that agreement. I understand that at any time I have the right to revoke this consent, provided I do so in writing, but that providers of services may still use information to complete any actions they began prior to my revoking consent and which rely on my protected health information. I understand that Kaye Eyecare of Huntley, Ltd. may refuse me further services if I revoke this consent.

I understand that Kaye Eyecare of Huntley, Ltd. may refuse me service if I refuse to sign this consent.

In addition, I also give permission to access my personal information to:

_____ (name) / _____ (relationship)

_____ (name) / _____ (relationship)

_____ By initialing here, I authorize Kaye Eyecare of Huntley, Ltd. personnel to **communicate by mail and/or email** for my protected healthcare information and other services according to the information provided in my patient registration information. I understand this consent is not a condition of being a patient and that I may revoke this consent, in writing, at any time.

Patient Email Address:_____

_____ By initialing here, I consent to **receive calls and/or voicemail messages** from Kaye Eyecare of Huntley, Ltd. for my protected healthcare information and other services according to the phone numbers I have provided in my patient registration information, including my wireless number provided. I understand I may be charged for such calls by my wireless carrier. I understand this consent is not a condition of being a patient and that I may revoke this consent, in writing, at any time.

Patient/Guardian Signature:_____ Date:_____

Consent for Treatment and Authorization to Release Information

I hereby authorize Kaye Eyecare of Huntley, Ltd., through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures. I further authorize Kaye Eyecare of Huntley, Ltd., to release information protected under the Health Insurance Portability and Accounting Act of 1996 acquired in the course of my or the above named patient's examination and treatment to appropriate agencies.

I understand that my medical records are confidential. I understand that by signing this consent form I am allowing my medical information to be released upon the request of my major medical and/or vision insurance company for the purpose of Health Care Operations (including, but not limited to, provider review functions, claims payment, and quality assessment). I also understand that I may revoke this consent by written request, at any time, with this doctor. If revoked, it is understood by all parties that all information released prior to being notified of such revocation was made with my consent. For additional information on your insurance company's confidentiality policy, please call their member services department.

I also understand that I have the right to restrict the disclosure of specific information in my medical records if I request such a restriction in writing. I also understand that my request for restriction may be denied if the information restricted is required by Health Care Operations.

I have read the above and foregoing consent for release of information. I do hereby acknowledge that I am familiar with and fully understand the terms and conditions of the consent.

Patient/Guardian Signature:_____ Date:_____

We would be happy to provide a copy of this signed form for your records upon request.