PATIENT ACKNOWLEDGEMENT
NOTICE OF PRIVACY PRACTICES (HIPPA)

Winter Park Vision Specialists

Consent of Disclosure

For Health Information For Treatment, Payment, and Health Care Operations

When providing you with service, we also create, receive and store health information that identifies you. We want to ensure you that we respect the privacy of your personal medical records. We also will do all we can to secure and protect your privacy, taking every reasonable precaution in safeguarding your confidentiality. It is often necessary to use and disclose your health information in order to treat you, obtain payment for our services, and to conduct health care operations involving our office. When it is appropriate and necessary, we provide the minimum necessary information to only those in need of your health care information.

You acknowledge and authorize that we may disclose your health information for treatment, payment for our services and to perform health care operations, which include:

- The use and disclosure of your health information for treatment purposes. Not only including care and services provided, but also disclosure of your health information. This may be necessary for you to receive follow up care from us or another health professional.
- The use and disclosure of your health information for the purposes of payment, including, but is not limited to, providing this information to your insurance company, third party, billing agent or other vendor for eligibility, determination of benefits, processing claims and receiving payments.
- We may have indirect treatment relationships with other organizations, in which we may have to disclose personal health information for purposes of treatment , payment or healthcare operations.
- That support personnel employed by this professional practice or any affiliated agencies, vendors or companies, including optical personnel will have access to your health information.
- The payment of medical insurance benefits to the Winter Park Vision specialists or Vision Developments or other appointed agencies or parties who may accept assignment for services provided.

You have the right to restrict or revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI)

_____ _____

Signature (Guardian) Date