ACKNOWLEDGEMENT & CONSENT

I understand that **InVision Eye Care, PLLC**, (referred to below as "The Practice") will use and disclose **health information** about me in order to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims, and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I also understand that I have the right to receive and review a written description of how the Practice will handle health information about me. This written description is known as a **"Notice of Privacy Practices"** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of the Practice, and my rights regarding my health information.

I understand that the *"Notice of Privacy Practices"* may be revised from time to time, and that I am entitled to receive a copy of any revised *"Notice of Privacy Practices"*. I also understand that a copy or a summary of the most current version of the Practice's *"Notice of Privacy Practices"* in effect will be posted in the reception area.

I understand that I may revoke my authorization at any time by notifying the person/organization providing the information in writing, except to the extent that: action has been taken in reliance on this authorization; or if this authorization is obtained as a condition for obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy.

By signing below, I agree that I have reviewed and understand the information above and that <u>I have reviewed</u> a copy of the "Notice of Privacy Practices."

By: _____ Date: _____
(Patient)

-OR-

By: _____ Date: _____
(Patient Representative)
Description of Representative's Authority: _____