



Brandy E. Hicks, OD
Phone: (828) 586-8080 • Fax: (828) 586-8066
400 East Main St. • P.O. Box 2218 • Sylva, NC 28779

Notice of Privacy Policies & Consent Form

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The *Notice of Privacy Practices* you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our *Notice of Privacy Practices*, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our *Notice of Privacy Practices* will be updated whenever our privacy practices change. You can get an updated copy here at the office.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our *Notice of Privacy Practices*.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our *Notice of Privacy Practices*, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our *Notice of Privacy Practices* describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the *Notice of Privacy Practices* from Mountain View Eye Care.

Signature

Date

If signing as a personal representative of the patient, describe the relationship to the patient.

Relationship to patient

Date



Brandy E. Hicks, OD

Phone: (828) 586-8080 • Fax (828)586-8066
400 East Main St. • P.O. Box 2218 • Sylva, NC 28779

OPTOMETRIC RECORDS RELEASE FORM

Patient Name: _____

Date of Birth: _____ **Social Security Number:** _____

Other Names Records May be Under: _____

Records to be Released From: _____

I authorize the facility listed above to disclose my protected health information as described on this form to MOUNTAIN VIEW EYE CARE. I have read this authorization and understand what information will be disclosed, who may disclose the information and the recipient(s) of that information. I understand that when the information is disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below.

- My entire medical record.
- Last eye exam with most current spectacle and contact lens prescriptions
- This authorization will expire on _____. After this date, it can no longer be used to disclose my health information without first obtaining a new authorization form.

I fully understand and accept the terms of this authorization.

PATIENT SIGNATURE _____

WITNESS SIGNATURE _____