**PATIENT HIPAA CONSENT FORM**

**I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996(HIPAA). I UNDERSTAND that by signing this consent form I authorize you to use and disclose my protected health information to carry out.**

* **Treatment (including direct or indirect treatment by other health care providers involved in my treatment);**
* **Obtaining payment from third party payers (e.g. my insurance company);**
* **The day-to-day healthcare operations of your practice.**

**I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the use and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time and that I may contact you at any time to obtain the most current copy of this notice.**

**I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these restrictions. However, if you do agree, you are then bound to comply with this restriction.**

**I understand that I may revoke this consent, in writing at any time. However, any use or disclosure that occurred prior to date I revoke this consent is not affected.**

**FORMULARIO DE CONSENTIMIENTO PACIENTE HIPAA**

**Entiendo que tengo ciertos derechos a la privacidad con respecto a mi información de salud protegida. Me reciben estos derechos bajo la ley de rendición de cuentas de 1996(HIPAA) y transferibilidad de seguros médicos. Entiendo que al firmar este formulario de consentimiento que te autorizo a usar y revelar mi información de salud protegida para llevar a cabo.**

* **Tratamiento (incluyendo tratamiento directa o indirecta por otros proveedores de cuidado de la salud involucrados en mi tratamiento);**
* **Obtención de pago de terceros pagadores (por ejemplo mi compañía de seguros);**
* **Las operaciones diarias de la atención médicos de su práctica.**

**También he sido informado de y teniendo en cuenta el derecho de revisar y asegurar una copia de su aviso de prácticas de privacidad, que contiene una descripción más completa del uso y divulgación de mi información de salud protegida y mis derechos bajo HIPAA. Entiendo que ustedes reservan el derecho de cambiar los términos de este aviso de tiempo y que le comuniquemos con usted en cualquier momento para obtener la copia más reciente de este aviso.**

**Entiendo que tengo derecho a solicitar restricciones sobre cómo mi información de salud protegida es utilizada y revelada para llevar a cabo tratamientos, pagos y operaciones de atención médica, pero que no están obligados a aceptar estas restricciones. Sin embargo, si usted está de acuerdo, que luego están obligados a cumplir con esta restricción.**

**Entiendo que puedo revocar este consentimiento por escrito en cualquier momento. Sin embargo, cualquier uso o divulgación que ocurrieron antes de la fecha que revocar este consentimiento no es afectada.**

**PATIENT NAME (NOMBRE DE PACIENTE): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SIGNATURE (FIRMA) : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Los Fresnos Eye Clinic & Optica**

**810 W Ocean Blvd Ste C2**

**Los Fresnos , Texas 78566**

**Dr. Antonio Vasquez**

**Therapeutic Optometrist**

**Optometric Glaucoma Specialist**

**PATIENT REGISTRATION**

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SEX: \_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE: \_\_\_ ZIP: \_\_\_\_\_**

**MAILING ADDRESS IF DIFFERENT FROM ABOVE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**AGE: \_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**WHOM MAY WE THANK FOR REFFERING YOU? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**RESPONISIBLE PARTY**

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_RELATIONSHIP TO PATIENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE: \_\_\_ ZIP: \_\_\_\_\_\_\_\_\_**

**EMPLOYER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OCCUPATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**REASON FOR VISIT**

**\_\_\_ EYE EXAM \_\_\_ GLASSES \_\_\_ CONTACT EXAM/MATERIALS \_\_\_ MEDICAL EXAM \_\_\_ REFRACTIVE SUGERY**

**OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I CERTIFY THAT I HAVE READ AND UNDERSTOOD THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE AND HAVE BEEN ACCURATELY ANSWERED.**

**SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**