**Contacts and Glasses, Inc.**

**Drs. Ronda and Frank Morreale**

**1950 N. Wickham Road**

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**Phone: 321-752-5454 Fax: 321-752-5405**

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**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 I authorize Contacts and Glasses, Inc. to use and disclose my protected health information to carry out:

\*Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);

\*The day-to-day healthcare operations of Contacts and Glasses, Inc.

I understand that Contacts and Glasses, Inc. reserves the right to change the terms of this notice from time to time and that I may contact the office 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 Contacts and Glasses, Inc is not required to agree to these requested restrictions. However, if Contacts and Glasses, Inc. does agree Contacts and Glasses, Inc. is 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 the date I revoke this consent if not affected.

\_\_\_\_\_ I hereby authorize that Contacts and Glasses, Inc. may leave messages on my voicemail to confirm appointments, and/or may speak with other members of my household to leave messages with them regarding my appointments: \_\_Cell phone \_\_Home phone \_\_Work phone

\_\_\_\_\_ I hereby authorize that Contacts and Glasses, Inc. may disclose my personal health information to the following person(s):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ do hereby consent and acknowledge my agreement to the terms set forth in the

(print name)

HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(print name of minor)

Patient or Responsible Party Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_