NOTICE OF PRIVACY POLICY

In order to protect the privacy and confidentiality of your health information, Infinity Eye Care and their team members are requesting your permission to provide information to individuals other than yourself.

Please Identify individuals that you AGREE to allow Infinity Eye Care to communicate with regarding your healthcare or billing information via telephone, fax, or in person.

NAME:_____ RELATIONSHIP:_____

NAME:_____ RELATIONSHIP:_____

NAME:_____ RELATIONSHIP:_____

- I **AGREE** that information directly related to my healthcare and billing can be released to family members, relatives, close personal friends, or any other person that **I have identified above.**

- I **AGREE** to be contacted by telephone, mail, or e-mail for appointment conformations, follow-up about treatments or test results, in an emergency at work, and that you may leave messages on my answering machine.

If you disagree to any of the above statements, please write DISAGREE beneath that statement.

I acknowledge that I have received a copy of Infinity Eye Care's Notice of Privacy Practices, which describes how my medical information is used, disclosed, and how I may access this information. I hereby authorize the physician to release any information required to process my insurance claim. I also authorize my insurance benefits be paid directly to the physician, and I understand that I am responsible for any non-covered services or goods.

PATIENT'S PRINTED NAME:_____

PATIENT'S SIGNATURE:_____ DATE:_____
(OR LEGALLY AUTHORIZED INDIVIDUAL)

Relationship to patient, if signed by anyone other than the patient. (Parent/Legal Guardian, Personal Representative, etc.)_____

If you have any questions or concerns please contact our Office Administrator (HIPAA Compliance Officer) at (540) 731-1010 or by fax (540) 731-1007.