TAYLOR & MURPHY OPTICAL
DR. WENDY CRUSBERG
545 HOOKSETT ROAD, #23, MANCHESTER, NH 03104
HIPAA PRIVACY PRACTICES

I UNDERSTAND THAT UNDER THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA), I HAVE CERTAIN RIGHTS TO PRIVACY REGARDING MY PROTECTED HEALTH INFORMATION.

I UNDERSTAND THAT THIS INFORMATION CAN AND WILL BE USED TO:

1.) CONDUCT, PLAN AND DIRECT MY TREATMENT AND FOLLOW UP AMONG THE MULTIPLE HEALTH CARE PROVIDERS WHO MAY BE INVOLVED IN THAT TREATMENT DIRECTLY OR INDIRECTLY.

2.) OBTAIN PAYMENT FROM THIRD PARTY PAYERS.

3.) CONDUCT NORMAL HEALTHCARE OPERATIONS SUCH AS QUALITY ASSESSMENTS AND PHYSICAL CERTIFICATIONS.

I HAVE BEEN INFORMED BY YOU OF OUR NOTICE OF PRIVACY PRACTICES CONTAINING A MORE COMPLETE DESCRIPTION OF THE USES AND DISCLOSURES OF MY HEALTH INFORMATION. I HAVE BEEN GIVEN THE RIGHT TO REVIEW SUCH NOTICE OF PRIVACY PRACTICES PRIOR TO SIGNING THIS CONSENT. I UNDERSTAND THAT THIS OFFICE HAS THE RIGHT TO CHANGE ITS NOTICE OF PRIVACY PRACTICES FROM TIME TO TIME AND THAT I MAY CONTACT THIS OFFICE AT ANY TIME AT THE ADDRESS ABOVE TO OBTAIN A CURRENT COPY OF THE NOTICE OF PRIVACY PRACTICES.

I UNDERSTAND THAT I MAY REQUEST IN WRITING THAT YOU RESTRICT HOW MY PRIVATE INFORMATION IS USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS. I ALSO UNDERSTAND YOU ARE NOT REQUIRED TO AGREE TO MY REQUESTED RESTRICTIONS, BUT IF YOU DO AGREE THAT YOU ARE BOUND TO ABIDE BY SUCH RESTRICTIONS. I UNDERSTAND THAT I MAY REVOKE THIS CONSENT IN WRITING AT ANY TIME TO THE EXTENT THAT YOU ARE BOUND TO ABIDE BY SUCH RESTRICTIONS. I UNDERSTAND THAT I MAY REVOKE THIS CONSENT IN WRITING AT ANY TIME TO THE EXTENT THAT YOU HAVE TAKEN ACTION RELYING ON THIS CONSENT.

PATIENT NAME:_____

SIGNATURE:_____

RELATIONSHIP TO PATIENT:_____ DATE:_____