

Digby Eye Associates

Notice of Privacy Practices

Patient Name: _____

By signing this consent, you are giving the providers and office staff permission to use and disclose your health information. Your health information will be used and disclosed to provide your care and treatment, to bill and collect payment for services provided, and to perform necessary routine office operations.

You may wish to review and/or receive our complete "Notice of Privacy Practices." Please ask our reception staff for this copy if you so desire. You will be given time to review the notice and ask any questions that you may have prior to signing this consent.

We reserve the right to change the privacy policy as stated in the "Notice of Privacy Practices." You will be given a copy of the revised notice with your first office visit following any change. The most current notice is prominently posted in our waiting room and you may request a copy at any time.

You have the right to request that we restrict how your health information is used or disclosed. We are not required to agree to your requested restriction, but if we do agree to the restriction, we will honor the restriction.

You have the right to revoke this consent except to the extent that we have already taken action covered under the consent. If you choose to revoke this consent, you must do so in writing.

Please indicate any persons you wish for us to communicate your personal health information with:

_____ relationship _____

_____ relationship _____

I have read and understand the above Notice of Privacy Practices and hereby give my consent to the use and disclosure of my personal health information as outlined above.

_____ Date _____
Signature of patient or responsible party