EYE ASSOCIATES of North Jersey, P.A

OPHTHALMOLOGY & OPHTHALMIC SURGERY

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HIPPA COMPLIANCE PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we use or disclose protected health information.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare. The HIPPA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of information for treatment, payment, or healthcare.

By signing this form, you, the patient, understand that:

- **Protected health information may be disclosed or used for treatment, payment, or healthcare operations.**
- **The practice reserves the right to change the privacy policy as allowed by law.**
- **The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.**

May we call to confirm appointments? **YES** **NO**

May we leave a message on your answering machine at home or on your cellphone? **YES** **NO**

May we discuss your medical condition with any memeber of your family? **YES** **NO**

If YES, please name the member allowed below:

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Print Name (patient): ______________________________

Signature: ______________________________

Email: ____________________________ **Date:** ____________