THÔNG BÁO VỀ NGUYÊN TẮC QUYỀN RIÊNG TƯ

HIPAA PATIENT CONSENT / RECEIPT OF NOTICE OF PRIVACY PRACTICES FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent, which is posted in the office. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, temporarily, in administrative areas such as the front office, examination room, etc. and may contain any coding which identifies a patient's condition or information which is not already a matter of public record. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient's records, (PHI, protected health information) and other documents or information. Record request can take up to 30 days with a $50.00 charge assessed to the patient. Requests from physicians will be done at no charge.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and the Patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices, should it become necessary within the law.
- The Patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.

I am a patient of Hung Le Eye Center. I hereby consent and acknowledge my agreement to the terms set forth in the HIPPA consent/receipt of Hung Le Eye Center's Notice of Privacy Practices, and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Name (please print): ____

Signature (Ký Tên): ____

Date: ____

OR

I am a parent or legal guardian of ____(patient name). I hereby acknowledge receipt of Hung Le Eye Center's Notice of Privacy Practices with respect to the patient.

Name (please print): ____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: ____

Date: ____

Physician's you would like to include in communication of your health records.

____

FOR OFFICE USE ONLY _

We attempted to obtain a written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

______ Patient / Patient's legal representative **refused** to sign. (please circle)

______ Communication barriers prohibited obtaining the acknowledgement.

______ Emergency circumstances prevented securing acknowledgement.

______ Other (please specify) ____

Le Eye Institute

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