Consent & Acknowledgement of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, Mermaid Optical creates and maintains health records and other information describing, among other things, my or my child's health history, symptoms, examinations and test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the used and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change the Notice and Practices prior to implementation and will mail a copy of the revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting premium rating, conducting, or arranging for medical review, legal services and audit functions, etc.) and the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me or my child for the purposes of treatment, payment, and healthcare operations. I have the right to revoke this consent in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format are confidential and cannot be disclosed for reasons outside of treatment, payment or healthcare operations without my prior written authorization, except otherwise provided by law.

2. A photocopy or fax of this consent is as valid as this original.

3. I have had the right to request that the use of my protected health information, which is used or disclosed for the purposes of treatment, payment, or healthcare operations be restricted. I also understand that the Practice and I must agree to terminate any restrictions in writing on the use and disclosure of my protected health information, which have been previously agreed upon.

Patient name printed

Date

Patient signature (or Guardian if a minor only)

S.S. # (for identification purposes)

Facility representative

Date

Retain in patient record

Nov. 2020