HIPAA Permissions and Restrictions

Under the terms of the Health Insurance Portability and Accountability Act of 1996 and our privacy policy, we may and will release to necessary entities (i.e. your insurer, laboratories, a pharmacy) any information needed by them for treatment, payment, or health care operations. When you accepted your insurance, you may have already authorized the insurer to be given any information necessary for its handling of your claims. Workers' compensation insurers will demand information of us without further permission from you.

This form will clarify certain aspects and implications of the rules and allow you to grant or deny permission for some actions which qualify as disclosure of information. Anyone who has attained the age of 18 and retains his or her civil rights may make this authorization for himself or herself. This is true without regard to who is the insured or who is paying for the patient's care.

Patient's Name _____ birthdate _____

By my signature below, I (or my representative) indicate acceptance of the above conditions and acknowledge receipt of the statement of privacy practices for Drs. Distin & Doyle.

List below the names and birthdates of all others to whom we may communicate about the patient named above. Also, please list any restrictions that may apply to a particular individual.

_____ birthdate _____
restriction(s)_____

_____ birthdate _____
restriction(s)_____

_____ birthdate _____
restrictions(s)_____

_____ birthdate _____
restrictions _____

I also **give deny** permission for doctors or staff at Drs. Distin & Doyle to leave telephone messages and text messages at telephone numbers I have

provided and to send appointment or dispensing reminders by postcard. Further, I **give deny** permission for other patients or those in their company to be in the same open area or room as I select a frame or have my glasses or contact lenses dispensed or adjusted or as I wait while my eyes are dilating. I also **give deny** permission for doctors or staff to speak my name on the premises in the presence of other persons not in my company. Finally, I acknowledge I have no further questions about this document and I give permission for _____ to accompany me during this visit today.

This statement is **an initial a replacement** statement and applies until **replaced** _____ **(date)**

Signature . . . . . date _____

Printed name _____

____patient ____patient's representative

representative's relationship or credentials _____

Our computer system assigns -- but we do not use -- account numbers, examination numbers, patient numbers. We prefer to use your name to identify you and will strive to remember that name too. Please understand that while we wish to respect our patient's privacy, no practice can survive never having more than one patient in the building at a time. If you must have exclusive use of the frames area or do not wish to have your name spoken in the presence of other people, we welcome your suggestions on avoiding those situations and will execute them if they are feasible.