Notice of Privacy Practices

Patient Name-[printed]: ____

As our Patient, we are offering you a copy of Midwest Eye Institute's Notice of Privacy Practices to retain for your information/reference. Copies are also available at any time from our reception desk, on our website, or directly from the doctor's office. You are welcome to review, or have a copy of, this notice at any time upon request.

Signature Required: Your signature is required below indicating that the entirety of the Midwest Eye Institute Privacy Practices policy has been shared with you. By signing you also acknowledge that an actual copy of this entire policy has been offered to you. A copy of this signature page will be maintained in your medical chart.

Patient Signature: ______________________________ **Date:** ____________________

Authorization for Release/Disclosure of Health Information

This section should not be completed unless the patient agrees to a PHI release. If release of the patient's PHI to anyone other than the referring physician is not required, **this section is NOT required. By signing this section, you authorize your Midwest Eye provider to disclose your PHI to your immediate family, including but not limited to, your parents, your spouse, and your adult-aged children.** You may see and copy the information described on this form if you ask for it, and you can receive a copy of this form after you sign it, should you request one.

Name of Person(s) and/or Organization(s) OTHER THAN immediate family member or referring physician(s) authorized to receive information:

1. ______________________________ Relationship: ____________________
2. ______________________________ Relationship: ____________________

Limitations to this Authorization must be identified below. Such as: If you don't want us to release/disclose your PHI to certain family member(s), please list those individuals below. If this portion of the form is left blank, it is assumed that the information for released is unrestricted.

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As a patient I understand and accept the following statements:

- If my physician has initiated this Authorization, I understand that in most cases I will be treated regardless of whether I sign this authorization. However, if the purpose of the Authorization is to allow research-related treatment, I understand I may not be able to get that treatment without signing this form.
- I hereby authorize the release / use / disclosure of my individually identifiable health information (a/k/a Protected Health Information of PHI) as described above. I understand that this authorization is voluntary. I also understand that if the person or organization authorized to receive the information is not a health plan, health care provider, or contracted business associate of this practice or Midwest Eye Institute, the released information may no longer be protected by federal privacy regulations.

[Note: If the patient is unable to sign for themselves and/or is underage, or if there is a Medical Power of Attorney in effect, a legal guardian or the POA must sign this release below as "patient representative" If this Authorization has been initiated by anyone other than the patient, their legal guardian or the patient's authorized representative, the patient may refuse to sign this Authorization.]

Signature of Patient, Legal Guardian, or Patient Representative ____________________ Date: __________

Printed name of Guardian or Representative: ____________________ Relationship to Patient: __________

Witness (required if not signed by the patient): ______________________________ Date: __________

Expiration date (optional): ______ /______ /______ *(MM/DD/YY) or on the occurrence of the following event:*

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This authorization may be revoked at any time by notifying your Midwest Eye Physician in Writing