# HIPAA PRIVACY POLICY
## ACKNOWLEDGEMENT AND CONSENT

I understand that Horn Optometric, LLC may use and disclose health information about me.

I understand that my health information may include information both created and received by this practice, may be in the form of written or spoken words, and may include information about my health history, health status, symptoms, examination, test results, diagnoses, treatment, procedures, prescriptions, and similar types of health related information.

I understand and agree that this practice may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment.
- Refer to, consult with, coordinate among, and manage along with other healthcare providers for my care and treatment.
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my healthcare; and
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective healthcare.

I also understand that I have the right to receive and review a written description of how this practice will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff, and other office personnel of this practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of this practice's Notice of Privacy Practices in effect will be available in the waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that this practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and I have received a copy of privacy practices.

Signed: ______________________________________________ Date:__________

- ○ Yes I would like to give consent to disclose my health information to specific family members or friends. If yes, please list names of those you would like us to have on file.

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