WINSTON EYE CARE

HIPAA* Authorization for Use or Disclosure of Health Care Information

101 Laguna Rd. Suite C Fullerton, CA 92835

My signature at the bottom of this form along with my response to the specific items indicated below; authorize the use and disclosure of my health information by Dr. Winston, his associates and his support staff.

My response to the following specifies with a YES or NO indicates my desires with respect to releasing my health information for the purpose indicated.

Yes ☐ No ☐ Dr. Winston may inform anyone who answers my indicated home or work telephone number of my future eye appointments, attempts to secure me a future eye appointment, results of testing or the arrival of my ophthalmic materials (eyeglasses or contact lenses which require my attention).

Yes ☐ No ☐ Dr. Winston may leave voice mail messages on my indicated home or work telephone numbers inform me of future eye appointments, attempts to secure me a future eye appointment, results of testing or the arrival of my ophthalmic materials, which require my attention.

Yes ☐ No ☐ Dr. Winston may send post cards to my indicated home address to notify me of my future eye appointments, attempts to secure me a future eye appointment or arrival of my ophthalmic materials, which require my attention.

Yes ☐ No ☐ Dr. Winston may allow anyone who accompanies me to my eye appointments to sit in the exam room and hear details of my medical history as it applies to my eye doctor visit.

Yes ☐ No ☐ Dr. Winston may discuss my health problems with immediate family or others listed below. Please list their names below to discuss or release any information:

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I also understand that every reasonable effort will be made at all times by Dr. Winston, his associates and support staff to protect medical health information in Dr. Winston's practice. Dr. Winston has also requested that any of his business associates who receive my health information in the course of my treatment, will also make every reasonable effort to protect that health information.

A complete Notice of Privacy Practices is posted in our office for your review. You may request a copy of this document, which details the steps our office is taking to keep your health information confidential.

I understand I have the right to revoke this authorization in writing at any time by sending a letter to Jeffrey V. Winston, M.D. 101 Laguna Rd. Ste. C Fullerton, CA 92835. Exceptions to a revocation of permission include uses or disclosures already made based upon my original permission and as a condition of securing insurance coverage and the insurer has the right by law to contest a claim or policy which requires my health information.

I also understand that, as a security measure, a proof of identity will be requested from me at the time of every visit.

Patient Authorization: ____________________________ Date signed: ____________________

*The Health Insurance Portability and Accountability Act of 1996 also known as HIPAA is a set of rules which protect the privacy of individually identifiable health information.