

### **Patients' Privacy Rights**

Your rights under the federal Health Insurance Portability and Accountability Act (HIPAA) include:

1. **The right to receive the "Notice of Privacy Practices"**: This informs you of your rights and how to exercise them. The "Notice of Privacy Practices" is on public display and a copy is available to you in our office upon request.
2. **The right of Access**: You may request inspection of your medical record and may request copies. There is a fee to produce the copies. The process to follow and how to request copies is explained in the "Notice of Privacy Practices".
3. **The right to Request an Amendment or Addendum**: The "Notice of Privacy Practices" describes how to file a request for an amendment or addendum to your medical record.
4. **The right to an Accounting of Disclosures**: We can be asked to account for certain disclosures of your protected health information other than those you requested. The "Notice of Privacy Practices" describes how to request an accounting.
5. **The right to Request Restrictions**: You have the right to request restrictions on how we will communicate with you, or your family, or how we will release information.
6. **The right to Complain**: You have the right to complain if you think that your privacy rights have been violated. The "Notice of Privacy Practices" describes where to file a complaint, either within or outside of East Bay Retina Consultants, Inc.

#### **Please Note:**

We routinely send out post card, email or text reminders for your eye appointment and/or tests by mail to the home address you provide, or leave messages on answering machines on phone numbers you provide. In addition, we may discuss your medical condition with those who identify themselves as your immediate family (parents, siblings, children or spouse), other close relatives, and significant others, unless you have specifically asked us not to. We may also leave medical information on answering machines or send it to you by mail, fax, email, or other means. If you wish to have any information which we routinely disclose in this manner to be withheld, please mention it to your physician, or any of our staff. You will be asked to sign a different form.

I have read and I understand the above information.

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Patient's Signature

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Date