St. Peter Eyecare Center 320 Sunrise Drive St. Peter, MN 56082
FORM: NOTICE OF PRIVACY PRACTICE SUMMARY

-This summary discloses how health information about you may be used. A full notice of your privacy rights has also been provided to you if requested. Signature acknowledges the acceptance of the long form office privacy policies.
-St. Peter Eyecare Center uses health information about you for treatment, to obtain payment for treatment with your authorization as required (check your state laws), for administrative purposes, and to evaluate the quality of care that you receive.
-St. Peter Eyecare Center will not disclose your information to others unless you tell us to do so, our summary states we can/will, or unless the law authorizes or requires us to do so. St. Peter Eyecare Center may use your information to provide appointment reminders, information about treatment alternatives or other health-related issues.
-St. Peter Eyecare Center may disclose your information for public health activities, to funeral directors to enable them to carry out their activities, for organ and tissue donations, research, health and safety, governmental function in order to comply with worker compensation laws and regulations, a right to request restriction, report and retain a copy of your health record, request communication of your information by alternative means at alternative locations, revoke your authorization and request an accounting of your health records.
-You may complain to St. Peter Eyecare Center's HIPAA officer and/or to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.
-St. Peter Eyecare Center must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for reasons other than those listed above and mentioned in detail within an available full notice if requested and permitted under law.
-By signing I also acknowledge my right to my glasses and contact lens prescription. Unless declined, St. Peter Eyecare policy is to print a contact lens prescription for all contact lens users. Signature below is acknowledgement of receipt of a contact lens prescription, if applicable, once the evaluation has been paid. Additional requests can be made at any time.

If you have any questions or complaints, please contact St. Peter Eyecare Center's HIPAA officer at (507)931-6436.

Please list any additional individuals (such as parents of children over 18 or adult children of the signing adult) that you approve our office to release any and all protected information to. If you would like to remove anyone previously listed below, please line out their name and date:

Approved individuals (First and Last Name; Plus Relationship):

Patient Agreement to above:

Patient Signature Date

Patient Signature Date

Patient Signature Date

INSURANCE AUTHORIZATION: I request that payment of authorized Insurance benefits for any services furnished to me, be made on my behalf to St. Peter Eyecare Center.
I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable for related services.
I understand that I am responsible for charges not paid by the insurance plan and that I am responsible for expenses both known and unknown released by my insurance company. St. Peter Eyecare Center is not responsible for the determination of my insurance plan's coverage.
Patient Signature: Date

Reapproval Dates and Initial: _____, _____