SightTrust Eye Institute

Notice of Health Information Practices

I have been provided the opportunity to read, or it has been read to me, the Notice of Health Information Practices SightTrust.

I understand that SightTrust is committed to treating and using protected health information about me responsibly.

I understand my rights as they relate to my records at SightTrust and understand how information about me may be used and disclosed.

I understand that my health record is the physical and legal property of SightTrust, but the information belongs to me. I may have access to inspect, amend or obtain a copy of my health information. Costs will incur for copies of my records, and appointments must be made with the Privacy Officer to inspect, access or amend my health information.

I understand that SightTrust is required to maintain the privacy of my health information. SightTrust will require my authorization to release my health information to outside sources with the exception of disclosures for the purposes of Treatment, Payment and Healthcare operations. These may include: access to my health information by SightTrust staff and physicians: billing to myself or to a third-party payer; in addition, business associates of SightTrust, may from time to time, have access to my health information, but, I am assured that proper Business Associates Agreements are in place, insuring the protection of my health information; upon the physicians best judgement, we may disclose to a family member, relative or close personal friend or any other persons you identify, health information relevant to that person's involvement in my care; may be used for research data; funeral directors; organ procurement; marketing; FDA; public health or legal authorities; and/or law enforcement purposes.

SightTrust may call me with appointment reminders, cancellations and may leave voice messages at my home or place of employment.

I have read and understand the Health Information Practices of SightTrust.

HIPAA Contact List

SightTrust and its associates and staff have my permission to speak to the following family members/friends in reference to my medical care:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

SightTrust; its associates and staff have my permission to leave a message on my home answering machine: yes _____no _____and/or call me at my place of work: yes _____no_____

Patient Signature: _____ Date: _____