

## Authorization for Release of Information – Compound Release

Name of Patient _____	Date of Birth _____
<p><u>LOOKING GLASS EYE CENTER</u> is authorized to release protected health information about the above-named patient in the following manner and/or to selected persons.</p>	

Check each person/entity approved to receive information.	Check type of information that can be given to person/entity on the left in the same section.
<input type="checkbox"/> Voice Mail	<input type="checkbox"/> Results of lab tests/x-rays <input type="checkbox"/> Other _____
<input type="checkbox"/> Other person (s) (provide name and phone number)	<input type="checkbox"/> Financial <input type="checkbox"/> Medical
<input type="checkbox"/> Email communication-Provide email address* _____ *For email communication to occur, please accept the disclosure below:	<input type="checkbox"/> Financial <input type="checkbox"/> Medical <input type="checkbox"/> Appointment reminders <input type="checkbox"/> Breach notification
<input type="checkbox"/> Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below:	<input type="checkbox"/> Appointment reminder <input type="checkbox"/> Other: _____
<input type="checkbox"/> For <b>email and/or text communication</b> I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	
<input type="checkbox"/> Photo of patient received by patient or legal guardian <input type="checkbox"/> Photo taken by staff (Example: pre/post procedure) <input type="checkbox"/> Other	<input type="checkbox"/> May be posted in office <input type="checkbox"/> May be posted on website <input type="checkbox"/> Other _____

<p><b>Patient Rights:</b></p> <ul style="list-style-type: none"> <li>I have the right to revoke this authorization at any time by contacting our office.</li> <li>I may inspect or copy the protected health information to be disclosed as described in this document.</li> <li>Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.</li> <li>Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.</li> <li>I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.</li> </ul>
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This authorization will remain in effect until revoked by the patient.

\_\_\_\_\_  
 Signature of Patient or Personal Representative

Date \_\_\_\_\_

\*Description of Personal Representative’s Authority (attach necessary documentation)

**LOOKING GLASS EYE CENTER**  
**Acknowledgement of Receipt**  
**Of Notice of Privacy Practices**

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Patient Name & Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I have received a copy of the Notice of Privacy Practices for the above named practice.

\_\_\_\_\_  
Signature Date

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For Office Use Only

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**We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:**

- An emergency existed & a signature was not possible at the time.
- The individual refused to sign.
- A copy was mailed with a request for a signature by return mail.
- Unable to communicate with the patient for the following reason:  
\_\_\_\_\_
- Other: \_\_\_\_\_  
\_\_\_\_\_

Prepared By \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

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### Notice of Privacy Practices

Effective date: April 14, 2003

Revision Date: 6/15/2022

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED BY **LOOKING GLASS EYE CENTER** AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

**YOUR RIGHTS:** When it comes to your health information you have certain rights. This section explains your rights.

**Upon written request:**

- Ask to see or get an electronic or a paper copy of your health record or other information we have about you. We will also provide a summary of your health information if requested. We will charge a reasonable, cost based fee. We will provide this information as soon as possible but no later than 30 working days of the request.
- Ask us to correct your health information you think is incorrect or incomplete. We may say “no” but will tell you why in writing within 60 days.
- You can ask us to communicate with you in a certain way (for example, home or office phone) or to send mail to a different address. We will accommodate all reasonable requests.
- Ask us not to use or share certain health information for treatment, payment or our operations. We are not required to agree with your request and may say “no” if it would affect your care.
- If you pay for a service or health care item out of pocket in full and you ask us not to share that information for payment or our operations with your health insurer we will agree unless we are required by law to share that information.
- Ask us for a list or an accounting of the times we have shared your health information for reasons other than treatment, payment, healthcare operations, and when you have asked us to share information. We will provide a list for the past six years for the request. One request per year will be provided free of charge. For additional requests we will charge a reasonable, cost based fee.
- Revoke an authorization to use or disclose PHI at any time except where action has already been taken.

**You may also:**

- Choose someone to act on your behalf. If you have given someone medical power of attorney or they are your legal guardian, that person can exercise your rights and make choices about your health information. We will ask for proof of this relationship before we take any action.
- Ask for a paper copy of this document even if you have agreed to receive the notice electronically. We will provide that copy promptly.
- File a complaint if you feel your rights have been violated you may contact the designated Privacy Officer, Stacy Smith, 215 Thompson Street, Hendersonville, NC 28792, 828-693-4161 and [ssmith@lookingglasseye.com](mailto:ssmith@lookingglasseye.com).
- File a complaint with the US Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave, S.W., Washington, D.C. 20201, calling 1.877.696.6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints](http://www.hhs.gov/ocr/privacy/hipaa/complaints).
- We will not retaliate for filing a complaint.

**OUR RESPONSIBILITIES: The law requires us to:**

- Maintain the privacy and security of your protected health information.
- Notify you promptly if a breach occurs that may compromise the privacy or security of your information.
- Follow the duties and privacy practices described in this notice and give you a copy of it.
- Not to use or share you information other what is described in this notice unless you tell us we can in writing. If you tell us we can and then change your mind, just let us know in writing you have changed your mind.

### Looking Glass Eye Center

188 Medical Park Dr, Ste C  
Brevard, NC 28712  
828-884-7320 Fax 828-884-7944

215 Thompson Street  
Hendersonville, NC 28792  
828-693-4161 Fax 828-697-1028

**YOUR CHOICES - For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in situations described below, talk to us.**

- In these cases you have both the right and the choice to tell us to: share information with your family, close friends, or others involved in your care and share information in a disaster relief situation.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

- In these cases we never share your information unless you give us written permission:
  - Marketing purposes
  - Sale of your information
  - Most sharing of psychotherapy notes
  - In the case of fundraising, we may contact you for fundraising efforts, but you can tell us not to contact you again.

**OUR USES AND DISCLOSURE – We typically use or share your health information in the following ways:**

**Treatment:** We can use your health information and share it with other professionals who are treating you. Example: we may share your health information to an outside doctor for referral. We will also provide your health care providers with copies of various reports to assist them in your treatment.

**Payment:** We can use or share your health information to bill and get payment from health plans or other entities. Example: we give information about you to your health insurance plan so it will pay for your healthcare.

**Health Care Operations:** We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: we use health information about you to manage your treatment and services.

**Other ways we can use or share your health information** – We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

- **Help with public health and safety issues:** We can share health information about you for certain situations such as: preventing disease, helping with product recalls, reporting adverse reactions to medication, reporting suspected abuse, neglect, or domestic violence, and preventing or reducing a serious threat to anyone’s health and safety.
- **Comply with the law:** We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see if we are complying with federal privacy law.
- **Respond to organ and tissue donation requests:** We will share health information about you with organ procurement organizations.
- **Work with a medical examiner or funeral director:** We can share health information with a coroner, medical examiner, or funeral director when you die.
- **Address workers’ compensation, law enforcement, and other government requests:**
  - For workers’ compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services
- **Respond to lawsuits and legal actions:** We can share your health information to respond to a court or administrative order, or in response to a subpoena.
- **Research:** We can use or share your information for health research.

**CHANGES TO THIS NOTICE - We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office and on our website [www.lookingglasseye.com](http://www.lookingglasseye.com).**

Stacy Smith, Business Office Manager, Privacy Officer  
Email: [ssmith@lookingglasseye.com](mailto:ssmith@lookingglasseye.com)

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