



Notice of Privacy Practices

1660 Western Ave, Albany, NY 12203
518-218-7970 (Phone)
518-218-7919 (Fax)

We are required by law to maintain the privacy of your health information and to provide you notice of our legal duties and privacy practices with respect to your health information.

The following are some examples as to the way we use and disclose health information:

- ∞ For treatment
- ∞ For payment
- ∞ For health care operations
- ∞ Appointment Reminders
- ∞ Treatment recommendations/ alternatives and/or services/benefits
- ∞ Individuals involved in your care (or payment of your care)
- ∞ See hand out for more detailed explanation

We will use and disclose your health information as required by federal, state and local law without your authorization.

Right to complain: If you have questions about this notice or would like to file a complaint about our privacy practices, please direct inquires to The U.S. Department of Health & Human Services, Office of Civil Rights, 200 Independence Avenue, S.W. , Washington, DC 20202, or call toll free 877-696-6775.

By signing below you acknowledge that you have reviewed a copy of the privacy practices of Casey Vision Care.

By signing this form, I acknowledge that I reviewed a copy of Casey Vision Care's Notice of Privacy Practices.

I further consent to the release of my health information for the purposes of treatment, payment, and health care operations and as authorized or required by law under the circumstances described above and in the Notice of Privacy Practices.

I have supplied the current and correct insurance information and will notify the office immediately of any changes in coverage. Your insurance is a contract between you and the insurance company.

Patient Name: _____

Signature: _____ Date: _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form.

Relationship to Patient: _____

Print Name: _____

Source of Authority: _____