DENVER VISION THERAPY

Developing Visual Excellence
Leanna Dudley, OD, FCOVD
Developmental Optometrist

Effective: 08/07/2014

NOTICE: PATIENT PRIVACY PRACTICES

We are required by law to protect the privacy of your medical information and to provide you with written Notice describing:

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

We may use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for the care that we provide to you, and the related administrative activities supporting your treatment.

We may be required or permitted by certain laws, regulations, or circumstances to use and disclose your medical information for certain purposes without your authorization. Under other circumstances we may need your written authorization (that you may later revoke) in order to use or disclose your medical information.

As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We can have available a detailed NOTICE OF PRIVACY PRACTICES which fully explains your rights and obligations under the law. We may revise our NOTICE from time to time. The Effective Date at the top right hand side of this page indicates the date of the most current notice in effect.

This practice uses email as a means of communication between patient/ legal guardian(s) of the patient. The contents of any email message and any attachments are intended solely for the addressee(s) and may contain confidential and/or privileged information and may be legally protected from disclosure. While not all email and internet are encrypted, our practice is not liable for the security of online communication. You may choose to opt out of email correspondence at any time by notifying our staff.

You have the right to receive a copy of our most current NOTICE in effect. If you have not yet received a copy of our current NOTICE, please ask at the front desk and we will provide you with a copy. If you have any questions, concerns, or complaints about the NOTICE or your medical information, please contact Dr. Dudley at Denver Vision Therapy at 303-433-3277.

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HIPAA Privacy Practices

-I understand that Denver Vision Therapy (referred to below as "This Practice") will use and disclose health information about me.

-I understand that my health information may include information both created and received by the practice, may be in the form of written or electronic records, or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of heath related information.
I understand and agree that this practice may use and disclose my heath information is order to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment; and
- Perform various office, administrative, and business functions that support my doctor's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

-I also understand that I have the right to receive and review a written description of how The Practice will handle health information about me. This written description is known as Notice of Privacy Practices and describers the uses and disclosures of health information made and the information practices followed by the employees, staff, and other office personnel of This Practice, and my rights regarding my health information.

-I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that the copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be available at any time.

-I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received or have been offered a copy of the Notice of Privacy Practices.

By: _____ Date: _____
(Patient or Patient Representative Signature)

Patient Name: _____

If Patient Representative, relationship to Patient: _____

Effective 7/22/13