Drs. James & Enyart Optometrists, S.C.

Your Vision Source Headquarters

Oregon Clinic
185 W. Netherwood St.
Oregon, WI 53575
P: (608) 835-3579
F: (608) 400-0290

Monona Clinic
700 River Place
Madison, WI 53716
P: (608) 223-0202
F: (608) 440-8220

www.jamesandenyart.com
jamesandenyart@gmail.com

Health Insurance Portability and Accountability Act (HIPAA)

At Drs. James and Enyart Optometrists, maintaining your trust and confidence is a high priority. With this form, you can review our **Notice of Privacy Practices** information, available on our website, **jamesandenyart.com or by request.** This notice explains the use and disclosure of your healthcare information. You have the right to review this notice before you sign this consent form. We reserve the right to change our privacy practices described in the notice: if we make a change, we will notify you in writing at the time of your next appointment or by mail.

There are circumstances in which we may have to use or disclose your healthcare information. We may disclose it to another healthcare provider or hospital if it is necessary to refer you for diagnosis assessment, or treatment of your condition. We may also disclose your health information and billing records to another party if they are responsible for payment of your services.

Your Right to Limit Use of Disclosures

You have the right to limit disclosure at any time of your health information to specific individuals, companies, or organizations. If you choose to limit disclosure, please inform us in writing. We are not required to agree to your restrictions; however, if we do agree, the restrictions are binding on us.

Your Right to Revoke Your Authorization

You may revoke any authorization at any time. We will honor your request from the date we receive written notification. **(Please note: If you revoke authorization from your insurance carrier, claims cannot be submitted on your behalf.)**

Appointment Reminders and Your Healthcare Information

Drs. James and Enyart may need to use your name, address, telephone number, and your records to contact you with appointment reminders, information about treatment alternatives, and/or other health related information that may be of interest to you. If we contact you by telephone, we may leave a message on your voice mail, with whomever answers at your preferred number or send a text message. By signing this form, you authorize us to contact you with reminders and information. You have the right to refuse this service; refusing this service will not affect your care. You may inspect or copy any information we use to contact you to provide appointment reminders, information about treatment alternatives, or other health information at any time.

This notice is effective as of the date signed below. This authorization will expire seven (7) years after the date on which you last receive services from us.

I have read and I understand the above statements describing confidentiality and insurance. My signature below indicates that I accept and agree to these terms. I authorize Drs. James and Enyart Optometrists to contact me with reminders and information that may be pertinent to my care.

_____
Print Name of Patient

_____ _____ _____
Signature of Patient OR Guardian/Authorized Representative | Relationship | Date