ARGOS VISION AND EYECARE CENTER
15920 Shady Grove Rd
Gaithersburg, MD 20877

HIPAA PATIENT NOTIFICATION RECEIPT AND FAMILY ACCESS TO PROTECTED HEALTH INFORMATION

Patient Full Name _____ Today's Date _____

Patient Date of Birth _____/_____/_____

PATIENT NOTIFICATION RECEIPT

I understand that as part of my healthcare, Argos Vision and EyeCare Center maintains health records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning and carrying out medical care and treatment; a means of communication among many health professional who contribute to my medical care and treatment; a source of information for applying my diagnosis and surgical information to my bill; a means by which third-party payers can verify that services were actually provided: a tool for routine health care operations such as quality assurance, audits and assessments.

I have been provided with the **HIPAA Notice of Information Practices** that provides a complete description of Protected Health Information uses and disclosures. I understand that I have a right to complain, consent, object, restrict and/or request correction or amendment of my Protected Health Information, I understand that all such requests must be in writing and that Argos Vision and EyeCare Center is not required to agree to any corrections or restrictions that I may request. I understand that I may revoke any consent that I may have given, in writing, except to the extent that Argos Vision and EyeCare Center has already taken action in reliance thereon.

ACCESS TO PATIENT CARE AND PROTECTED HEALTH INFORMATION

I hereby give permission to the person(s) listed below to inquire about information regarding my medical care. In order to obtain information by telephone, the party calling the practice must share date of birth.

Name	**Relationship**