OPHTHALMOLOGY ASSOCIATES OF SAN ANTONIO

210.223.5561
OphthalmologySA.com

PATIENT ACKNOWLEDGMENT REGARDING THE HEALTH INFORMATION PRACTICES OF OPHTHALMOLOGY ASSOCIATES OF SAN ANTONIO

I have been provided the opportunity to read, or have had read to me, the Notice of Health Information Practices at Ophthalmology Associates of San Antonio (OASA).

I understand that Ophthalmology Associates of San Antonio is committed to holding and using protected health information responsibly.

As it relates to my records at Ophthalmology Associates of San Antonio, I understand my rights and how information about me may be used and disclosed.

I understand that my health record is the physical and legal property of Ophthalmology Associates of San Antonio, but the information belongs to me. I may have access to inspect, amend, or obtain a copy of my health information. There is a cost for copies of my records, and appointments must be made with the Privacy Officer to inspect, access, or amend my health information.

I understand that Ophthalmology Associates of San Antonio is required to maintain the privacy of my health information. Ophthalmology Associates of San Antonio will require my authorization to release my health information to outside sources, with the exception of disclosures for purposes of Treatment, Payment and Healthcare Operations. These may include the following: access to my health insurance information by Ophthalmology Associates of San Antonio staff and physicians; billing to myself or third party payer; business associates of Ophthalmology Associates of San Antonio may, from time to time, have access to my health information, but I am assured that proper Business Associates Agreements are in place to ensure the protection of my health information; upon the physician's best judgment, OASA may disclose to a family member, relative, close personal friend, or any other persons I identify the health information relevant to that person's involvement in my care; research; funeral directors; organ procurement; FDA; public health or legal authorities; and/or law enforcement purposes.

I understand that I have the right to restrict certain disclosures of my personal health information to a health plan (including Medicare) when I pay out of pocket for a particular healthcare item or service.

I understand that I will be notified in the event of an unsecured breach of my personal health information.

Ophthalmology Associates of San Antonio may call me with appointment reminders or cancellations and may leave voice mail messages at my home or place of employment.

I have read and understand the Health Information Practices of Ophthalmology Associates of San Antonio.

Patient Signature: _____

Date: _____