DES PERES EYE CENTER

ACKNOWLEDGMENT OF PRIVACY PRACTICES AND HIPAA DISCLOSURE AUTHORIZATION

Receipt of Notice of Privacy Practices:

_____ *(Initial)* I acknowledge I have received or I have been provided the opportunity to receive a copy of Des Peres Eye Center's (DEC) Notice of Privacy Practices that explains when, where and why my protected health information may be used or shared by DEC.

HIPAA Disclosure Authorization(s):

_____ *(Initial)* I authorize DEC to leave a message on my voicemail &/or other electronic means at the following number(s):
_____

_____ *(Initial)* I authorize DEC to provide the following person(s) with my protected health information:

Print Name:_____ Relationship to Patient_____

Print Name:_____ Relationship to Patient_____

Print Name:_____ Relationship to Patient_____

_____ *(Initial)* <u>I DO NOT</u> authorize DEC to disclose my protected health information to anyone other than myself, except as permitted by HIPAA as described in DEC's Notice of Privacy Practices.

I understand the HIPAA Disclosure Authorization(s) above may be revoked in writing at any time; however, the revocation will not affect disclosures of information previously authorized.

SIGNATURE REQUIRED ON BACK SIDE OF FORM

INFORMED CONSENT FOR TELEMEDICINE SERVICES

Telemedicine involves the use of electronic communications (phone, computer, etc) to enable health care providers to share medical information with a patient.

EXPECTED BENEFITS:

- Improved access to medical care by enabling a patient to remain in his/her location while the healthcare provider provides medical information at a distant site.
- Limiting the spread of COVID-19 and other communicable diseases.
- Ability to obtain consultation from a distant medical specialist without traveling.
- Allow medial evaluation and management of patients who are unable to travel.

POSSIBLE RISKS: As with any medical procedure, there are risks associated with the use of telemedicine. These risks include, but not limited to:

- Information transmitted may not be sufficient to allow for appropriate medical decision making by the health care provider. For instance, certain parameters of the eye exam cannot be tested remotely, such as eye pressure. In addition, there could be poor resolution of images. This could cause delay in evaluation and treatment.
- Security protocols could fail, causing a breach of privacy of personal medical information.
- A lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other medical errors.

CONSENT:

- You have read this informed consent form, or someone has read it to you.
- You understand the information in the informed consent and all of your questions have been answered.
- You have been offered a copy of this informed consent form.

NAME OF PATIENT _____ DATE OF BIRTH_____

Signature of Patient (OR person authorized to sign for patient): _____
If Authorized signer, relationship to patient: _____

DATE _____