

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent form I authorize you to use and disclose my protected health information to carry out:

- ✓ Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- ✓ Obtaining payment from third party payers (e.g. your insurance company);
- ✓ The day-to-day healthcare operations of our practice.

I understand that as part of my eye care, Somers Eye Center originates and maintains both electronic and/or hard copy records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care of treatment. I understand that this information serves as:

- ✓ A basis for planning my care and treatment;
- ✓ A means of communication among the many health professionals who contribute to my care;
- ✓ A source of information for applying your diagnosis and surgical information to your bill;
- ✓ A means by which a third-party can verify that services billed were actually provided;
- ✓ And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

Notice of Privacy

I understand that I have the option of receiving a copy of the Privacy Notification that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent form. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided, if a request is made.

Exclusions of Consent

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations and the organization is not required to agree to the restrictions requested.

Revoking Consent

I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I AGREE AND HAVE BEEN NOTIFIED ABOUT THE HIPAA REGULATIONS

I DO NOT AGREE TO THESE TERMS AND REGULATIONS

Print Name of Patient or Legal Representative

Date

Signature of Patient or Legal Representative