OPTICOLOGY
EYECARE

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Health-care Operations.

I understand that as part of my health-care, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or 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 my diagnoses and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine health-care operations such as assessing quality and reviewing the competence of health-care professionals.

I understand and may request the Notice of Information Practices 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. 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. I understand that I have the right to object to the use of my health information for directory purposes. 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 that the organization is not required to agree to the restrictions requested. 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 request the following restrictions to the use or disclosure of my health information:

Signature of Patient or Legal Representative Witness:

Accepted _____ Denied _____

Patient Name (Print): _____

Signature: _____

Date: _____