Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, 2020 Ophthalmic Associates, P.C. originates and maintains paper and/or electronic 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, which may include discussion with family members for emergency or medical necessity.
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis 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 healthcare operations such as assessing quality and reviewing the competence of healthcare professionals. **If you wish to make any <u>restrictions</u> please do so in the space below:**

_____

☐ I agree to allow 20/20 Ophthalmic Associates to call for any matters related to my healthcare and leave a message if I am not available, either a voice message or with the person that answers the phone.

☐ I understand 20/20 Ophthalmic Associates will fax documents pertinent to my healthcare to those entities that are part of my TPO. I understand that faxed documents cannot be encrypted and can be at risk for unintentional disclosure of my health and personal information.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures.* I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- 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

I understand that 2020 Ophthalmic Associates, P.C. 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 also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.***

I further understand that 2020 Ophthalmic Associates, P.C. reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations.

* I acknowledge that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

My signature indicates I understand the terms of this consent form.

_____

Patient's Signature

_____** **Expiration date is 2 years from date signed.

Date

*** The Notice of Information Practices entitled <u>*Notice of Privacy Practices*</u> is located in the waiting room.**