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 healthcare, 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 provided.
- A tool for routine health-care operations such as assessing quality and reviewing the competence of health-care professionals.

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 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.

Individuals Authorized to Receive My Health Information:

I consent to the sharing of my health information with the following individuals (family members, caregivers, etc.):

Name: _____ Relationship _____

Name: _____ Relationship _____

Name: _____ Relationship _____

Signature of Patient or Legal Representative Witness:

Patient Name (Print): _____

Signature: _____ Date: _____