Jewel City Optometry
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NOTICE OF PRIVACY PRACTICES

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPTIONS

Patient name_____D.O.B._____

Patient address_____

Patient phone number_____

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office.

We have a comprehensive Notice of Privacy Practices that describes these uses and disclosures in detail. You have the right to refer to this Comprehensive Privacy Policy at any time before you sign this consent document. As described in our Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes not only includes care and services provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes our submission of your health information to a billing agent or vendor for processing claims or obtaining payment: our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; our submission of your health information to auditors hired by third-party payers and insurers, among other aspects of payment described in our Notice of Privacy Practices. We reserve the right to amend the terms of our Comprehensive Privacy Policy. You may obtain an updated copy of the current policy by requesting one in person or by calling our office at 818.240.3937. When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perform health care operations. You can revoke this consent in writing at any time. Your cancellation must be in writing signed by you or on your behalf and will only become effective upon receipt of your signed and dated cancellation notice. Your cancellation will not be effective for past services in which we or others have acted in reliance upon this consent.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment, or health care operations, but as described in our Notice of Privacy Practices, we are not obligated to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our Notice of Privacy Practices describes how to ask for a restriction.

I HAVE READ THIS CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

_____ _____

Dated Patient

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

_____ Print Name_____

Source of Authority:_____

Requested Personal Copy of Comprehensive Notice of Privacy Practices: Sign & Date_____

Declined Personal Copy of Comprehensive Notice of Privacy Practices: Sign & Date_____