

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

I, (please print name) _____, understand that as part of my health care, the Eye Clinic of Bellevue LTD, P.S. 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 including phone message notifications to me about appointments;
- 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, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I have been offered to be 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 and
- 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 the Eye Clinic of Bellevue 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 164.520 of the Code of Federal Regulations. Should the Eye Clinic of Bellevue change their notice, the most recent revision will be available at the reception desk or on our website at eyeclinicofbellevue.com.

I wish to allow the Eye Clinic of Bellevue to provide information from my record to the following person(s) on their request:

Name _____ Relationship _____

Name _____ Relationship _____

I wish to have the following restrictions to the use of disclosure of my health information: _____

I understand 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 or electronically.

I fully understand and accept the terms of this consent. Date _____

Patient's Signature _____ Date of Birth _____

Authorization to Leave Personal Health Information by Alternate Means

- May leave detailed message on voicemail at home # () _____
- May leave detailed message on voicemail at work # () _____
- May leave information with spouse (name) _____
- May leave information with other family member _____
- May leave detailed message on cellular phone # () _____
- May leave detailed message at a different location # () _____

With my signature below I acknowledge and understand that this information will be kept in my medical record and the above parameters will be abided by until revoked by me in writing. It is my responsibility to notify my healthcare provider should I change one or more of the telephone numbers listed above.

Signature of Patient _____ Date _____