**Consent to the Use and Disclosure of Health Information**
**For Treatment, Payment or Health Operations**
**And**
**Acknowledgement of Receipt of "Notice of Privacy Practices"**

I understand that as part of my healthcare, Eyecare Professionals office originates and maintains records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care and/or treatment. I understand 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 means by which a 3rd party payer can verify that services billed were actually provided.
- A tool for routine healthcare operation such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a "Notice of Privacy Practice" 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 Eyecare Professionals reserves the right to change the notice and practices and prior to implementation will make a copy of any revised notice to the address I have provided upon written request by me for the office to do so.

I understand that I have the right to see and obtain copies of my medical record upon written request and during normal business hours at a designated time set by Eyecare Professionals office. I understand that I have the right to request amendments be made to my medical record. All amendments need to be written on a separate sheet of paper and duly indicated "Amendment To The Record." I understand that a six year history of all disclosures will be accessible to me including the purpose of the disclosure and the address of the recipient. I may receive a copy of this history. 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 healthcare operations, but the Practice is NOT required to agree to the restrictions requested. If Eyecare Professionals office does agree to any restrictions, the agreement is binding on use. I understand that I may revoke this consent in writing, except that the Practice has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

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I hereby consent to the use and disclosure of my individual identifiable health information for treatment, payment and healthcare operation purposes.

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Signature of Patient/Parent/Legal Representative Date

**********Office Use Only**********

_____Accepted _____Denied

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Signature Title Date