

Jeffrey W. Williams OD & Associates P. A.

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

Patient Name _____ Patient Phone Number _____

Address _____ City _____ State _____ Zip _____

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 are free to refer to this Notice 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. Our Notice of Privacy Practices will be updated whenever our privacy practices change.

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

I authorized the professional office of my optometrist named above to release health information identifying me [including if applicable, information about HIV Infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following conditions:

1. Detailed description of the information to be released;
2. To whom may the information be released;
3. The purpose for the release;
4. Expiration date or event;

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization. You can also review your health information that we have before deciding whether to sign this authorization. Our Notice of Privacy Practices explains how to request access to your identifiable health information, and how we may respond. Basically, you simply need to send a written request to the office contact person listed at the top of this form to initiate the process.

If you sign this authorization, you can revoke it later. The exceptions to this are if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed above.

When your health information is disclosed as provided in this authorization, the recipient has no duty to protect its confidentiality. The recipient may re-disclose the information as he/she wishes

We [will/will not] receive a financial benefit from disclosing this health information about you.
[The financial benefit is: _____]

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM

Date 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:

Relationship to Patient Print Name

Source of Authority