



SACRAMENTO CONTACT LENSES OPTOMETRY, INC.

SACRAMENTO
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Roseville, California 95661
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CONSENT TO USE OR DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

Patient Name _____

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 are free to refer to this notice at any time before you sign this consent document. As described in the 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 information to a billing agent or vendor for processing claims or obtaining payment, or submissions of claims to third-party payers or insurers for claims review, determination of benefits and payment, or submission of you 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. You can receive an updated copy at our office.

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. We may call, mail, or E-mail to remind you of scheduled appointments and to notify you of other treatments, services or information available at our office that might help you. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent. We can decline to serve you if you elect not to sign this consent form.

You have the right to ask us to restrict the uses of 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. We do agree, however, the restrictions are binding on us. Our Privacy Of Practices Notice 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 PUPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

DATE

PATIENT SIGNATURE

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 CONSENT.

RELATIONSHIP TO PATIENT (PRINT NAME)

SOURCE OF AUTHORITY