Eyesight Associates HIPAA Notice of Privacy Practices

Effective 10/01/2014

- I hereby authorize and request the medical treatment necessary for the care of the above named patient.
- I hereby give my consent for Eyesight Associates to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).
- I allow the electronic transmittal of my medical records, if necessary.
- I acknowledge full financial responsibility for services rendered by Eyesight Associates. I understand payment is due at the time of service unless other definite financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges.
- I may revoke my consent in writing except to the extent that Eyesight Associates has already made disclosures in reliance upon my consent. If I do not sign this consent or later revoke it, Eyesight Associates may decline to provide treatment to me.
- I further authorize and request that insurance payments be made directly to Eyesight Associates should they elect to receive such payment.
- I have received and or read a copy Eyesight Associates Notice of privacy practices that tells me my rights and how Eyesight Associates will use and disclose my protected health information.
- I have received a copy of the financial policy.

I have read and fully understand the above consent for treatment, release of protected health information, financial responsibility and insurance authorization.

In addition to my primary care physician and/or referring physician, you have my permission to share my medical information with the following:

_____ _____

_____ _____

_____ _____

Signature of Patient or Legal Guardian Date of Birth

_____ _____

Patient's Name Today's Date