Consent to the Use and Disclosure of Health Information

Patient : _____ Account : _____

Acknowledgement and Consent for the Use and Disclosure of Information
Our *Notice of Privacy Policies* provides information about how Rockville Eye Associates (REA) may use and disclose protected health information about you. Our *Notice of Privacy Policies* states that we reserve the right to change the terms described. Should this happen, the agreed upon policies will remain in effect until you are notified. You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or healthcare operations. We are not required to agree to your restrictions, but if we do, we are bound by our agreement with you.

By signing this form, you acknowledge receipt of our Notice of Privacy Policies and consent to our use and disclosure of protected health information about you for treatment, payment, and healthcare operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

Patient Signature: _____ Date Signed: _____

Personal Representative, Family or Other Entities Authorized Access to Protected Health Information to be Used and/ or Disclosed
Name or specifically identify these persons and/or other entities you are authorizing to make use of and/or disclose your protected health information regarding treatment, payment, and other healthcare operations.

_____

Name of Authorized Person or Entity Relationship #Phone

_____

Name of Authorized Person or Entity Relationship #Phone

It is important to note that this authorization is not completely restrictive. In the case that these entities cannot be reached during an emergency that prompts immediate disclosure of protected healthcare information, REA reserves the right to use professional judgment as needed.

Authorization for use of Patient Contact Methods
REA may be unable to contact patients directly during normal business hours. On these occasions, our office contacts patients and leaves messages through the communication devices provided by our patients. Due to the new federally mandated HIPAA Privacy Rule, we must obtain your authorization to continue this mode of communication. Protected Healthcare Information that we may possibly disclose on your home, work, cell phone, or email account includes, but is not limited to: test/lab results, prescription/pharmacy information, appointment instructions for visits and procedures, and surgical posting/scheduling information.

_____ Yes, I agree to allow REA to leave messages that includes Protected Healthcare information on any of these communication devices: home phone, work phone, cell phone, and/or email account

_____ No, I do not agree to allow REA to leave messages that includes Protected Healthcare information on any of these communication devices: home phone, work phone, cell phone, and/or email account.