CONSENT FOR USE OF PERSONAL HEALTH INFORMATION

THIS CONSENT FORM CONCERNS HOW WE MAY USE/DISCLOSE YOUR CONFIDENTIAL HEALTH INFORMATION.

Your Medical Health Information is Treated as Confidential. Quakertown Eye Associates, P.C. treats any information we have about you, your health, the health care you receive, or payment for that care, as confidential. We may use your health information for treatment, payment and health care operation purposes, but will not disclose it to third parties, except as provided below:

Summary of Permitted Disclosures of Health Information. The law permits us to disclose your health information for certain purposes, including:

- Your treatment, including notifying you for follow-up treatment or coordinating a consult with another provider;
- Payment for the treatment we (or other providers to whom we provide your health information) provide you, for example: to bill your insurer(s);
- Our health care operations or the operation of other covered entities to whom we provide your health information, for example: for quality assessment, auditing and training;
- As required by law, such as to report vital statistics, for law enforcement purposes, or for government investigations;
- For statistical and summary purposes, if the information cannot be used to identify you; and
- To our subcontractors and agents, with appropriate safeguards.

For other disclosures, including those related to referrals or requests for medical records, we must obtain specific permission (authorization) from you. Also, we generally must obtain your permission for disclosures when certain kinds of information (such as HIV/AIDS) are involved.

Restrictions on How We May Use and Disclose Your Health Information. You can ask us to restrict the medical information used or shared about you for treatment, payment and health care operations. We will tell you whether or not we can comply with your request.

I specifically **RESTRICT** the release of my information to: ☐ No restrictions _____

_____

I specifically **AUTHORIZE** the release of my information to (i.e. spouse, children, caretaker): ☐ No authorizations _____

_____

1. I have read, or if unable to do so, have had this consent form read to me by my representative or a staff member, and you or your representative agree with its terms.

_____ _____

PRINT PATIENT NAME **PRINT** REPRESENTATIVE NAME (if *other* than patient)

X_____ _____ ☐ Self

SIGNATURE of Patient or Patient Representative Relationship to Patient

_____ _____

Patient's Date of Birth Today's Date

2. Our Notice. Our Notice of Privacy Practices is a separate document that explains in detail how we use and disclose your health information. We have the right to change our Notice at any time. If there is a change in material, we will distribute a revised Notice to you.

Please Initial to indicate that you: ☐**HAVE RECEIVED** ☐**DO NOT WISH TO RECIEVE** a copy of our Notice of Privacy Practices ***X*_____ (INITIAL)**

3. I wish to be contacted by Quakertown Eye Associates, P.C. in the following manner (*CHECK ALL THAT APPLY*):

☐**Home Phone:**	OK to leave messages with information that is:	☐**Detailed**	**OR**	☐**Call Back Only**
☐**Work Phone:**	OK to leave messages with information that is:	☐**Detailed**	**OR**	☐**Call Back Only**
☐**Cell Phone:**	OK to leave messages with information that is:	☐**Detailed**	**OR**	☐**Call Back Only**
☐**Written**				