

## Consent to the Use and Disclosure of Health Information

I understand that as part of my health care, Baptist Eye Surgeons, PLLC originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment, I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a **Notice of Privacy Policies** that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Baptist Eye Surgeons, PLLC is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Baptist Eye Surgeons, PLLC reserves the right to change their notice and practices and to make the new provisions effective for all protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice", viewing our website at [www.baptisteye.com](http://www.baptisteye.com) or by visiting our office and picking up a copy.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures transmitted by electronic transmission, fax transmittal, or e-mail.

Please print the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care options).

Printed Name \_\_\_\_\_ Relationship \_\_\_\_\_ DOB \_\_\_\_\_ Phone \_\_\_\_\_

Printed Name \_\_\_\_\_ Relationship \_\_\_\_\_ DOB \_\_\_\_\_ Phone \_\_\_\_\_

Can confidential messages be left on your answering machine or voicemail? YES \_\_\_ NO \_\_\_

\_\_\_\_\_  
Patient's Name Printed

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date