Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

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 164.508 (4)(iii) 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 they obtain. If the information practices change, the notice will be amended and I understand that I am entitled to receive a revised copy of the Notice by calling 865-579-3920 and requesting a copy of the Notice or visiting the website at www.baptisteye.com, or visiting the office to request a copy.

I wish to have the following restrictions to the use or disclosure of my health information (persons we can't speak with or you wish to pay for your visit and us not bill insurance):

_____

_____

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: _____

We will need to use your information to contact you with automated appointment reminders or phone calls regarding other medical information. Do we have your permission to:

Leave a message on answering machine/voicemail: _____ Yes _____ No
Leave a message with your family member: _____ Yes _____ No
Receive text messages for appointment reminders: _____ Yes _____ No

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 via fax.

I understand that this consent will expire one year from the date of my signature.

_____ _____
Patient's Printed Name Patient Date of Birth

_____ _____
Patient's Signature Date