



CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Barnhorst Eye Associates will use your health related information for the purposes of providing you with medical treatment, obtaining payment for services rendered and/or through the following mechanisms: US Postal Service, fax submissions, internet submissions, voice mail and/or personal communications. The most common entities that will receive this information are: other providers, facilities, insurance companies and pharmacies. More specific information pertaining to our practice policies is provided for you in our "Notice of Privacy Practices" statement. You have a right to review this statement prior to receiving health care and prior to signing this consent. The terms of our "Notice of Privacy Practices" may change at any time. You may contact the office and request a revised policy. Also, if you so choose, you may request that we restrict the use of your health information for the purposes of treatment, payment, and/or health care operations. Our physicians are not required to agree with the restriction. If the physicians believe it is in your best interest to permit use and disclosure of your protected health information, this information will not be restricted.

I have received a copy of the "Notice of Privacy Practices" from Barnhorst Eye Associates. I consent to the above noted terms related to the use and disclosure of my individually identifiable health information for the purposes of treatment, payment and/or health care operation. I understand that this consent will remain in effect for six years, or until I revoke it in writing.

Patient name (printed): _____ Date: _____

Patient, parent or legal guardian signature: _____

Relationship to patient of the person signing : _____

Patient refusal:

The patient, parent or legal guardian has refused to sign the consent form.

Name of patient, parent or legal guardian: _____

Employee witness: _____ **Date:** _____