HIPAA

_____
Patient name

Consent for Purposes of Treatment, Payment, & Healthcare Operations

I consent to the use or disclosure of my protected health information by Somerset Ophthalmology PC for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Somerset Ophthalmology PC. I understand that diagnosis or treatment by the physicians of Somerset Ophthalmology PC may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Somerset Ophthalmology PC is not required to agree to the restrictions that I may request. However, if Somerset Ophthalmology PC agrees to the restrictions requested, the restriction is binding on the practice and its physicians.

I have the right to revoke this consent, in writing, at any time, except to the extent that Somerset Ophthalmology PC and its physicians has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a responsible basis to believe the information may identify me.

I understand I have the right to review Somerset Ophthalmology PC Notice of privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Somerset Ophthalmology PC.

Somerset Ophthalmology PC reserves the right to change the privacy practices that are described in the Notice of privacy Practices. I may obtain a revised notice of privacy practices by accessing Somerset Ophthalmology PC by calling the office & requesting a revised copy be sent in the mail or asking for one at the time of my appointment, or reviewing it on their website.

_____ _____
Patients Signature Date

_____
Guardian Signature (If Patient is under 18 years old)

Access to Private Health Information (PHI)

I _____ authorize the staff of Somerset Ophthalmology PC to release

PHI to the following family members/friends_____.
relationship

I authorize Somerset Ophthalmology PC to contact me concerning PHI through:

__Home/cell/voice mail phone#_____ ___leave a message

__ Work phone/voice mail#_____ ___leave a message