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

I, _____, understand that as part of my health care, Valley Vision Clinic 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. The HIPAA privacy regulations apply to everyone with access to personal medical information. At Valley Vision Clinic, we are committed to treating and using protected health information about you responsibly. We respect our legal obligation to keep health information that identifies you confidential. 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 information to my bill;
- A means by which a third-party payer can verify that services billed were actually provided;
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I acknowledge that I have been provided with or made aware of our *Notice of Privacy Practices* 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 Valley Vision Clinic 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 clinic 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 law.

I further understand that Valley Vision Clinic reserves the right to change their notice and practices, in accordance with applicable law. Should our information practices change, we will post the new notice in our office and on our web site, www.valleyvisionclinic.com.

I give permission for my Protected Health Information to be discussed for purposes of communicating results, finding and care decisions to the family members and others listed below:

Name	Relationship	Contact Number

I wish to have the following restrictions to the use or disclosure of my health information:

_____

I understand that as part of Valley Vision Clinic'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 and electronically.

I fully understand and accept / decline the terms of this consent.

Signature:_____ Date:_____
(Patient / Guardian / Legal Representative)

Relationship to patient:_____