ADVANCED EYECARE ASSOCIATES

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Advanced Eyecare Associates to use and disclose my protected health information (PHI) in order to carry out treatment, payment and healthcare operations (TPO).

I have the right to review the Notice of Privacy Practices prior to signing this consent. Advanced Eyecare Associates reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Practices may be obtained by forwarding a written request to Advanced Eyecare Associates located at 1832 Castleton Way in Delaware, OH 43015.

With this consent, Advanced Eyecare Associates may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, payment or healthcare operations (TPO), such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent Advanced Eyecare Associates may mail to my home or other alternative location any items that assist the practice in carrying out treatment, payment and healthcare operations (TPO), such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, Advanced Eyecare Associates may email to my home or alternative location any items that assist the practice in carrying out treatment, payment and healthcare operations (TPO), such as appointment reminder cards and patient statements. I have the right to request that Advanced Eyecare Associates restrict how it uses or discloses my Protected Health Information to carry out treatment, payment and healthcare operations. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Advanced Eyecare Associates to use and disclose my Protected Health Information to carry out treatment, payment or healthcare operations (TPO).

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Advanced Eyecare Associates may decline to provide treatment to me.

Patient or Guardian Signature _____

Patient Name_____

Date_____

Patient Number (office use only) _____

Original 08/27/2012