NORTHEAST EYE CENTER

PATIENT CONSENT FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, NORTHEAST EYE CENTER may use and disclose personal health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). They also have my consent to receive PHI about me from other medical facilities and practices for treatment purposes only. Please refer to NORTHEAST EYE CENTER Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. NORTHEAST EYE reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to NORTHEAST EYE CENTER at 711 Troy-Schenectady Rd. Latham, NY 12110-2454.

With my consent, NORTHEAST EYE CENTER may call/mail/e-mail/fax to my home or designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminder calls/cards/faxes/e-mails, insurance items/patient statements and any calls/mail/faxes/e-mails pertaining to my clinical care, including laboratory results among others.

I have the right to request that NORTHEAST EYE CENTER restrict how it uses or discloses my PHI to carry out TPO. However, 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 NORTHEAST EYE CENTER's use and disclosure of my PHI to carry out 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, NORTHEAST EYE CENTER may decline to provide treatment to me.

Signature Date:

Patient's Name: DOB:

Signature of Patient / Legal Guardian: ______________________________

Name of Legal Guardian: ______________________________

PRIVACY PRACTICES ACKNOWLEDGEMENT

By signing this form, I am acknowledging that I have been offered to review the Notice of Privacy Practices.

Signature of Patient / Legal Guardian: ______________________________

EMERGENCY CONTACT (s)

* Please list only Emergency Contact (s) you give permission for the doctor to discuss your condition and treatment plan with.

1.) ______________________________ Tel No (s) ____________________

2.) ______________________________ Tel No (s) ____________________

*** PHI (Protected Health Information); TPO (Treatment, Payment, & Healthcare Operations)**