Office Use Only

VisionHealth EyeCare PLLC
Inside Wal*Mart Vision Center
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CONSENT TO THE USE AND DISCLOSURE OF PROTECTED HEALTH CARE INFORMATION FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

Patient name________________________________Patient date of birth ___/___/_______

I understand that:

- As part of my health care, VisionHealth EyeCare PLLC originates and maintains health records describing my health history, symptoms, examinations, diagnoses, treatment, and (if applicable) vision and medical insurance information.

- The use and disclosure of my protected health information by VisionHealth EyeCare PLLC is necessary in order to provide me medical and vision care, to carry out the practice's health care operations, and to obtain payment for my examinations and treatments. Your glasses and/or contact lens prescription information is shared with the Logan, Utah Wal*Mart Vision Center as well as your exam fees, exam codes, and diagnoses names and codes are shared to facilitate payment collection.

- I have the option to receive a complete copy of VisionHealth EyeCare PLLC's Notice of Privacy Practices in the office located inside the Logan, Utah Wal*Mart Vision Center and also on the internet at http://www.visionhealtheye.com/hipaa . This document provides a complete description of the use and disclosure of my health information. I have the right to review that Notice prior to signing this consent. I also understand that VisionHealth EyeCare PLLC reserves the right to change the Notice and its privacy practices at any time. If I request, VisionHealth EyeCare PLLC will e-mail me a copy of any revised Notice prior to its implementation.

  - If you provided your e-mail, we will use it only to notify you that your prescription has expired, to advise you of any changes to the VisionHealth EyeCare PLLC Notice of Privacy Practices document, and any official correspondence from the doctor.

- (Optional) Please send my Physician a report after each eye exam regarding my vision and eye health to better coordinate care for my health condition(s). (This is helpful for patients with diabetes, high blood pressure, or other conditions where your doctor asks you to get an eye exam.) My initials__________. My physician's name and info:
  ____

- I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient signature _______________________________ Dated _______________________
If you are signing as a personal representative of the patient, describe your relationship to the patient or the source of your authority:

Name:_________________________________ Relationship to Patient:________________