NORTHSIDE VISION

HIPAA CONSENT

TO USE OR DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

Patient's Full Name: FIRST _____ MI LAST _____

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose some of this health information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office.

We have a comprehensive Notice of Privacy Practices (the "Notice") that describes these uses and disclosures in detail. You are free to refer to this Notice at any time before you sign this consent document. As described in our Notice, the use and disclosure of your health information for treatment purposes not only includes care and services provided here, but also disclosures of your health information as may be necessary and appropriate for you to receive the follow-up care from another health professional.

Similarly, the use and disclosure of your health information for purposes of payment includes our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; or submission of your health information to auditors hired by third-party payers and insurers, among other aspects of payment described in our Notice. Our Notice may be updated whenever our privacy practices change. You can get an updated copy here at the office.

When you sign this Consent document, you signify that you agree that Northside Vision can and will use and disclose your health information to treat you, to obtain payment for our services, and to perform health care operations. You can revoke this Consent in writing at any time unless we have already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this Consent. We can decline to serve you if you elect not to sign this Consent document.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment of health care operations, but as described in our Notice, we are not obligated to agree to these suggestions. If we do agree, however, the restrictions are binding on us. Our Notice describes how to ask for a restriction.

I HAVE READ THIS CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

Patient/Representative Signature_____ **Today's Date**_____

Effective To 1 Jan-2040 or _____

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If you are signing as a personal representative of the patient, please describe your relationship to the patient and source of authority to sign this form:

Relationship to Patient_____**Print Name**_____

Source of Authority (Relationship/legal right)_____

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If you wish to authorize Northside Vision to share your health information with a relative or other party, please specify what information may be shared and with whom (*i.e.* may we verify your appointment time to a spouse):

Information to Share: ☐ Share any/all information ☐ Share only: _____

Name of Party We May Share With: _____