AESTHETIC EYE, PC

OCULOFACIAL PLASTIC &
RECONSTRUCTIVE SURGERY

CONSENT TO USE OR DISCLOSE
MEDICAL INFORMATION

I authorize **AESTHETIC EYE, PC** to use and disclose the health and medical information of _____ for the purposes of Treatment, Payment and Health Care Operations.
(Name of patient)

- **Treatment** (includes activities performed by a physician, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers our practice by telephone as the on-call physician).
- **Payment** (includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, precertification and preauthorization).
- **Health Care Operations** (includes the necessary administrative and business functions of our office).

You may review **AESTHETIC EYE, PC** 'Notice of Privacy Practices' for additional information about the uses and disclosures of information described in this CONSENT prior to signing this CONSENT. Please verify that you have received a copy of our Notice by placing your initials here _ _____.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the Notice may change also. A summary of the Notice will be posted in the lobby of our office indicating the effective date of the Notice in the upper right hand corner. We will offer you a copy of the Notice on your first visit to us after the effective date of the then current Notice. We will also provide you with a copy of the Notice upon your request.

As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. ***We are not required to agree to your request.*** If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the Notice.

I understand that I have the right to revoke this CONSENT provided that I do so in writing, except to the extent that **AESTHETIC EYE, PC** has already used or disclosed the information in reliance on this CONSENT.

Can confidential messages (i.e. appointment reminders) be left at your:
Home: Yes ☑ No ☐
Office: Yes ☐ No ☐

Where do you prefer to receive messages? _____

_____ _____ (or)
Date *Signature of patient*

_____ _____
Date *Signature of person authorized by law*