RECEIPT OF NOTICE OF PRIVACY POLICIES & CONSENT FORM

Keller Eye Associates
Dr. Lauri Anderwald-Melton

Patient Name: _____ Phone Number: _____

Email: _____

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

The ***Notice of Privacy Practices*** you have been given describes uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our ***Notice of Privacy Practices***, the use and disclosure of your health information for treatment purposes not only includes care and service here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payments; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our ***Notice of Privacy Practices***. Our ***Notice of Privacy Practices*** will be updated whenever our privacy practices change. You can get an updated copy here at our office.

When you sign the consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our ***Notice of Privacy Practices***.

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

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, and healthcare operations. I acknowledge that I have received the ***Notice of Privacy Practices*** from Keller Eye Associates.

_____

Signature Date

If signing as a personal representative of the patient, describe the relationship to the patient:

_____

Relationship to patient Print Name

We will not disclose protected health information to anyone (including a spouse) unless you give us authorization to do so (only exception is parents of minor children).
I authorize Keller Eye Associates to disclose my protected health information to:

Name: Relationship:

- _____ Expiration date ___/___/___