Hudson Valley Eye Surgeons, PC

Patient Consent for Use and Disclosure of Protected Health Information (HIPAA)

With my consent, Hudson Valley Eye Surgeons, PC may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations.

I have the right to review the Notice of Privacy Practices prior to signing this consent.

Hudson Valley Eye Surgeons, PC reserves the right to revise its Notice of Privacy Practices at anytime. A revised notice may be furnished upon request.

With my consent, Hudson Valley Eye Surgeons, PC may call my home or other designed location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out healthcare operations, such as appointment reminders, insurance issues, clinical care, and lab results.

With my consent, Hudson Valley Eye Surgeons, PC may mail or email to my home or other designated locations any items that assist the practice in carrying out healthcare operations, such as reminder cards, patient statements, newsletter and satisfaction surveys.

I have the right to request that Hudson Valley Eye Surgeons restrict how it uses or discloses my PHI to carry out healthcare operations. 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 Hudson Valley Eye Surgeon, PC use and disclosure of my PHI to carry out healthcare operations.

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, Hudson Valley Eye Surgeons, PC may decline to provide treatment to me.

________________________________ ________________________________
Signature of Patient or Legal Guardian Relationship to Patient

________________________________ __________ ____________________
Print Name of Patient or Legal Guardian Date Account Number