Glaucoma Consultants of the Capital Region

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Glaucoma Consultants may use and disclose protected health information (PHI) about me in order to carry out treatment, receive payment for services, and other miscellaneous healthcare operations (TPO). Patients are encouraged to refer to the Glaucoma Consultants Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Glaucoma Consultants reserves the right to revise its Notice of Privacy Practices without notification at any time.

With my consent, Glaucoma Consultants may call my home and/or any other provided phone number(s) and leave a message on voice mail, or with other persons in reference to any items that assist our providers and staff in carrying out treatment, pursuit of payment for services rendered, or other miscellaneous healthcare operations (TPO). These calls may include, but are not limited to; appointment reminders, insurance concerns that pertain to my clinical care, and laboratory test results.

With my consent, Glaucoma Consultants may send mailings and/or packages to my home or other designated address to assist Glaucoma Consultants in carrying out miscellaneous healthcare operations (TPO). These mailing may include, but are not limited to; appointment card reminders, and patient statements.

I have the right to request that Glaucoma Consultants restrict how it uses and/or discloses my protected health information (PHI) to carry out healthcare operations (TPO). I understand that Glaucoma Consultants is not required to agree to my requested restrictions. I understand that if Glaucoma Consultants does agree to my requested restrictions, all restrictions will be specified on an attached form.

_____ [ ] I have no specific restrictions to my PHI

_____ [ ] I have specific restrictions to my PHI, and these restrictions are specified on an attached form.

By signing this form, I am consenting to Glaucoma Consultants Notice of Privacy Practices, and Glaucoma Consultants use and disclosure of my PHI to carry out TPO.

I understand that I may revoke my consent in writing except to the extent that Glaucoma Consultants has already made disclosures in reliance upon my prior consent. **I understand that if I do not sign this consent, Glaucoma Consultants has the right to decline to provide treatment to myself, or my dependent.**

Printed Name of Patient: _____

Printed Name of Legal Guardian if Applicable: _____

Patient or Legal Guardian Signature: _____ **Date:** _____