VISION SOURCE®
THE WOODLANDS

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

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 services and to conduct healthcare operations involving our office.

We have comprehensive notice practices that describe 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 of Privacy Practices the use and disclosure of your health information is necessary for you to receive follow up care from this office or 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 of claims, or obtain payment, our submission of claims to 3rd party payers for claims reviewed, determination of benefits and payments, our submission of your health information to auditors hired by 3rd party payers and insurers among other aspects of payment described in our Notice of Privacy Practices. Our Notice of Privacy Practices will be updated when our privacy practices changes. Whenever our practices change you can get an updated copy here at our office or from www.visionsource.com website.

When you sign this consent you signify 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. By signing you signify that you have no other health or vision insurance (or have provided us all insurance information) and agree that since there is no guarantee of payment by an insurance company you will be responsible for payment for services received in our office should the insurance not pay. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed healthcare 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 form.

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 Notices of Privacy Practices, we are not obligated to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our Notices of Privacy Practices 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.

Date _____ Signature of Patient/Representative _____

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

Relationship to Patient _____ Print Name _____