Oakland Vision Center Optometry

1960 Broadway
Oakland, CA 94612
Telephone 510-893-5566
Fax 510-893-3921

Consent to use or disclose health information for treatment, payment, and health care operations

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

We have a comprehensive Notice of Privacy Practices document that describes these uses and disclosures in detail. You are free to refer to this Notice at any time before you sign this consent document.

The use and disclosure of your health information for treatment purposes not only includes care and services provided here, but also disclosures of 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 our submission of your health information to a billing agent for processing claims review, determination of benefits and payment: submission of your health information to auditors hired by insurers.

When you sign this 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 health care operations. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed health care 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, but as described in our Notice of Privacy Practices, we are not obligated to agree to such restrictions. If we do agree, however, the restrictions are binding on us. To ask for a restriction, send a written request to our office address.

I give permission for the doctor to discuss my confidential medical information with:

_____ Relationship _____

_____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM. I ACKNOWLEDGE THAT I HAVE RECEIVED THE *NOTICE OF PRIVACY PRACTICES* FROM THE OFFICE OF OAKLAND VISION CENTER OPTOMETRY.

Date _____ Patient/Guardian Signature _____