SIERRA
EYE CARE

Receipt of Notice of Privacy Practices Policy and Consent Form

In the process of providing services to you, Sierra Eye Care creates, receives and stores 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 healthcare operations involving our office. The *Notice of Privacy Practices* you have been given describes these uses and disclosures in detail. You are free to refer to this notice at anytime before and after you sign this form. As described in our *Notice of Privacy Practices*, the use and disclosure of your health information for treatment 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 payment.
3. Our submission of your health information to auditors hired by our third-party payers and insurers.
4. Other aspects of payment described in our *Notice of Privacy Practices*.

You have the right to request that we restrict the uses and disclosures made for purposes of treatment, payment or healthcare operations. However, as described in our *Notice of Privacy Practices*, we are not obligated to agree to these requested restrictions. If we should agree, the restrictions are obligatory. Our *Notice of Privacy Practices* describes the process to request this type of restriction.

Our *Notice of Privacy Practices* will be updated whenever our privacy practices change. You may obtain an updated copy from our office or website.

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

I acknowledge that I have received the *Notice of Privacy Practices* from Sierra Eye Care and that the office can, and will, use and disclose my health information to treat me, obtain payment for any services I should receive and to perform healthcare operations as they pertain to me.

_____	_____	_____
Name	*Signature*	*Date*

If signing as a personal representative of the patient, indicate the relationship to the patient and the source of authority to sign this form on their behalf.

_____	_____	_____
Name	*Signature*	*Date*
_____	_____	
Relationship	*Source of Authority*	

For office use only

PHI History

Date	Action taken/Description	√ if a restriction	√ if a correction	Initials