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

I understand that I have certain privacy rights regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information for the purpose of carrying out:

- Treatment (direct or indirect) by other healthcare providers involved in my treatment, such as my primary care provider (PCP), specialists, and/or surgeons.
- Obtaining payment from third party payers (e.g. my insurance company). We do NOT guarantee the accuracy of benefit information provided to us by YOUR insurance. If you have questions, please contact your insurance company directly. You are responsible for all copays, deductibles, coinsurance, and any charges denied by your insurance. You are responsible for your account—NOT the insurance company. Quoted benefit coverages are estimates only. Eligibility and benefits are not a guarantee of payment. Any payment returned for insufficient funds will incur an additional $50 fee.
- ALL day-to-day healthcare operations of our practice.
- e-formats may be used to send and receive information using secure apps integrated with our EHR and/or direct messaging. To opt out you can notify us or reply 'STOP' at any time.
- Electronic access to your medical records and/or billing information is available 24/7 at: www.revolutionphr.com

I have been informed of, and given the right to review and secure a copy of, your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time, and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

**We require Optos digital retinal imaging on ALL of our comprehensive eye health exams. Optos retinal imaging is usually NOT covered by Vision Benefits and Medical Plans. You will be responsible for ALL fees due at time of service. Signature acknowledges our office policies, fees, copays, deductibles, etc. as quoted.
_____[Initials]

Cheyne Eye Center Staff may share my personal health information with others listed below for appointments, rescheduling, status of glasses and/or contacts, or delivery of optical goods ordered by or for the patient. Please print name and relation.

1. _____ Relation:_____

2. _____ Relation: _____

3. _____ Relation: _____

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name:_____

Signature: _____**Date:**_____

Relationship to Patient:_____ **Patient ID**_____