South Shore Eye Care LLP

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Date :_____

# Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for South Shore Eye Care, LLP to use and disclose protected health information (PHI) about me to carry out treatment payment and healthcare operations (TPO). (South Shore Eye Care, LLP's Notice of Privacy Practices provides a more complex description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. South Shore Eye Care, LLP reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Howard Lane, M.D., Privacy Officer, at 2185 Wantagh Avenue, Wantagh, N.Y. 11793.

With this consent, South Shore Eye Care, LLP may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, South Shore Eye Care, LLP may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, South Shore Eye Care, LLP may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that South Shore Eye Care, LLP restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement .

By signing this form, I am consenting to South Shore Eye Care, LLP's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

### *Release of Information*

❑ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

❑ Spouse _____ ❑ Other_____

❑ Child(ren) _____

❑ Information is not to be released to anyone.

**IF I DO NOT SIGN THIS CONSENT, OR LATER REVOKE IT, SOUTH SHORE EYE CARE, LLP MAY DECLINE TO PROVIDE TREATMENT TO ME.**

| _____ | _____ | _____ |
|---|---|---|
| **Signature of Patient or Legal Guardian** | **Print Patient Name** | **Print Legal Guardian Name** *(if appl)* |