AESTHETIC EYE, PC

Oculofacial Plastic & Reconstructive Surgery

Consent for Use and Disclosure of Health Information:

I,_____, authorize Aesthetic Eye, PC to use and disclose the health and medical information for the purposes of treatment, payment and healthcare operations.

- Treatment: Includes activities performed by a physician, nurse, office staff, and other types of health care professionals providing care to you. This is to include coordination or management of your care with third parties and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers our practice by telephone as the on-call physician.
- Payment: Includes activities involved in determining your eligibility for health plan coverage, billing, and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, precertification and preauthorization.
- Health Care Operations: Includes the necessary administrative and business functions of our office.

Notice of Privacy Practices:

You may review the Notice of Privacy Practices for Aesthetic Eye, PC for additional information about the uses and disclosures of information described in this consent prior to signing below. If you would like to view this please ask the receptionist for a copy.

You have the right to request restrictions on how we use and disclose your protected health information for treatment, payment and health care operations purposes. Please be aware that we are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the notice of privacy practices.

The below signature acknowledges the above statements:

_____

Signature of patient or responsible party

_____ _____

Name of patient or responsible party Date