

WHIDBEY VISION CARE, INC. P.S.

380 S.E. Barrington Dr., Oak Harbor, WA 98277 (360) 675-2235
P.O. Box 1048, 1690 Main St., Suite 103, Freeland, WA 98249
(360) 331-8424
Contact Person: Linda Waldrop

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

Patient Name _____

You have the right to read our Notice of Privacy Practices that describes the use of your health information. These disclosures are not only for the purposes of your treatment, care and services provided here, but also disclosures of your 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 or vendor for processing claims or obtaining payment; our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; our submission of your health information to auditors hired by third-party payers and insurers, among other aspects of payment described in our Notice of Privacy Practices.

When you sign this consent document, you signify that you have received, read and understand the Notice of Privacy Practices. Additionally, 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 may decline to serve you if you elect not to sign this consent form.

You have the right to ask us in writing to restrict the uses or disclosures made for purposes of treatment, payment or health care operations, but as described in our Notice of Privacy Practices, we are not obligated to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our Notice of Privacy Practices describes how to ask for a restriction.

I HAVE READ THIS CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

Patient Signature _____ Date _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship _____ Your Name _____

If you require an interpreter, translator, or other aid, for the purpose of understanding this notice, please advise the office staff. These services will be provided to you at no cost.

OFFICIAL USE ONLY

We attempted to obtain written acknowledgement of receipt of our Privacy Practices, but acknowledgement could not be obtained because:

- _____ Individual refused to sign
- _____ Communication barriers prohibited obtaining the acknowledgement (interpretive/bilingual services offered)
- _____ An emergency situation prohibited obtaining acknowledgement