REED
Eye Care Center

Acknowledgement of Receipt

Consent to Use and Disclosure of Protected Health Information

Notice of Privacy Practices

Review our Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may choose to review the Notice prior to signing this consent. By signing below, you acknowledge that we have given you a copy of our Notice of Privacy Practices.

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by our practice or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your Protected Health Information.
Our office may or may not agree to restrict the use or disclosure of your Protected Health Information.
If we agree to your request, the restriction will be binding with our office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of Federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. However, you must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

I give permission for the use and disclosure of my health information as set forth above.

Patient or Legally Authorized Individual Signature

Print Patient's Full Name_____

Date_____ Time_____

Office Use ONLY:

Date_____ Time_____

(Over)

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ASSIGNMENT OF BENEFITS & AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize and request that payment of benefits by my insurance company be made directly to REED EYE CARE CENTER for services provided to me or my dependant. I understand that my insurance company may only cover a portion of the total bill. I further understand that I may be responsible for all charges not covered by this assignment of benefits. I understand that REED EYE CARE CENTER will assist me in receiving reimbursement as much as possible, but I am responsible for providing correct insurance information to REED EYE CARE CENTER in order to gain assistance.

I authorize REED EYE CARE CENTER to disclose necessary medical information to determine benefits for related services. Such disclosure will be only for reimbursement purposes for those services received.

By signing this statement you agree to be financially responsible for all charges, including charges that my insurance company determines are the patient's responsibility. This assignment will remain in effect until revoked in writing. A scanned copy of this assignment is considered to be as valid as the original.

Patient Name _____

Signature _____Date _____