BLOOMINGTON FAMILY EYECARE CENTER
ANDREW W. BACKUS, O.D., F.A.A.O.
6 HEARTLAND DRIVE, SUITE C
BLOOMINGTON, IL 61704
(309) 663-0303

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

Patient name: _____

Patient address: _____

Patient phone number: _____

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, obtain payment for our services, and conduct health operations involving our office.

We have a comprehensive ***Notice of Privacy Practices*** that describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this consent document. As described in our ***Notice of Privacy Practices***, the use and disclosure of your health information for treatment purposes not only includes care and services provided here, but also discloses 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 vender for processing claims or obtaining 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***. Our ***Notice of Privacy Practices*** will update whenever our privacy practices change. You can get an updated copy at our office.

When you sign this consent document, you signify that you agree that we can use and disclose your health information to treat you, to obtain payment for our services, and to perform health care operations. You may revoke this consent in writing at any time unless we have treated you, sought payment for services, or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent. We can decline to serve you if you elect not to sign this consent form.

You have the right to ask us 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 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 PRUPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

_____/_____/_____ _____
Date Signature

If minor, _____
Parent/Guardian Signature