Oregon Retina Center

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I,_____, understand that as part of my health care, Oregon Retina Center (hereinafter referred to as ORC) originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

May we leave messages/detailed medical information on your voicemail? □ Yes □ No

May we contact you at your place of employment? □ Yes □ No
If so, may we leave a message? □ Yes □ No

ORC may communicate with the following individuals regarding your treatment (examples are friends, relatives, peers):

Name:_____Phone:_____
Name:_____Phone:_____
Name:_____Phone:_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I understand that unless notified in writing otherwise, all communication with me by ORC will be at the address and phone number supplied by me.

I have reviewed Oregon Retina Center's Notice of HIPAA Privacy Policy. A copy of this policy will be provided to me upon request.

I fully understand and accept the terms of this consent and certify that I am the patient or the Authorized Agent, legal guardian, or Power-of-Attorney holder for the patient listed above and am legally able to sign on behalf of the patient.

_____ _____
Patient's Signature Date

FOR OFFICE USE ONLY
[ ] Consent received by_____on_____.
[ ] Consent refused by patient, and treatment refused as permitted.
[ ] Consent added to the patient's medical record on .