Eye Care for the Adirondacks
Malone-Office
75th Sixth Street, PO Box 604, Malone, NY 12953 Office Phone 518.483.0065 Office Fax 518.483.0809

Consent To The Use and Disclosure Of Health Information For Treatment, Payment Or Healthcare Operations

(The Practice provides this form to comply with the federal government's Health Insurance Portability and Accountability Act of 1996.)

I hereby consent to Eye Care *for the* Adirondacks' use and disclosure of my individually identifiable health information for the purposes listed above and other purposes relating to my treatment, the payment of my health care, and other health care operations of the practice.

In addition, I acknowledge that I received on the date indicated below a copy of Eye Care *for the* Adirondacks' Notice of Privacy Practices, which describes the obligations of Eye Care *for the* Adirondacks regarding its use and disclosure of my individually identifiable health information and my rights regarding this information.

I also understand the Eye Care *for the* Adirondacks reserves the right to change its notice and practices. If Eye Care *for the* Adirondacks changes the notice, I can obtain a revised copy by asking the administrator of the practice. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or other healthcare operations and that Eye Care *for the* Adirondacks is not required to agree to the restrictions requested. If Eye Care *for the* Adirondacks does agree to such restrictions, however, it will comply with such restrictions.

I request the following restrictions to the use of disclosure of my health information:

_____

Effective Date of Notice: April 14, 2003

_____Date: _____ _____

Signature of patient or patient's representative Witnessed by: ECFTA representative

Printed name of patient's representative: _____

Relationship to patient: _____

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