Eye Care for the Adirondacks
450 Margaret Street Plattsburgh, NY 12901 Phone (518) 566-2020 Fax (518) 566-8211

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 understand that as part of my healthcare, Eye Care for the Adirondacks creates and maintains health records describing my health history. I understand that Eye Care for the Adirondacks may use this information as:

1. a basis for planning my care and treatment;
2. a means of communication among many health professionals who contribute to my care;
3. a means by which third-party payers can verify that services billed were actually provided; and
4. a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

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:

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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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