New 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, Dr. Victor Bisignano, and Associates originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand this information serves as:

- A basis for planning my eye 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, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Dr. Victor Bisignano, and Associates are not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken 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.

I further understand that Dr. Victor Bisignano, and Associates reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Dr. Victor Bisignano, and Associates change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

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.

**If applicable to myself, I understand and consent to the release of my contact lens prescription to myself or any optical facility acting on my behalf to fill a contact lens purchase outside of Dr. Victor Bisignano, and Associates. I understand that I will be fully responsible for any ocular, visual or other problem caused by a defective or incorrect contact lens purchased outside of Dr. Victor Bisignano, and Associates practice.

I fully understand and accept / decline the terms of this consent.

_____ _____

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 _____.