JAMESBURG FAMILY EYECARE CONSENT FORM

333 Forsgate Drive Unit 6 Jamesburg, NJ 08831 Tel. (732)656-1515 Fax (732)656-1514 drspiewakm@gmail.com

Consent to use or disclose health information for treatment, payment, and health operations:

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 information in order to treat you, to obtain payment for our services, and to conduct health care operations.

We have a comprehensive Notice of Privacy Practices that describes these uses and disclosures in full detail. You are free to refer to this Notice at any time before you sign this consent document. As described in our Notice, the use and disclosure of your health information for purpose of treatment not only includes care and services provided here, but also disclosure of your health information as may be necessary or appropriate for you to receive follow-up care from another health care professional. Similarly, the use and disclosure of your health information for purpose of payment includes our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; our submission of claims to third-party payers or insurers, among other aspects of payment described in our Notice of Privacy Practices. Our Notice will be updated whenever our practices change. You may obtain a copy at our office or on our website.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment, and to perform health care operations. You can revoke this consent in writing at any time unless we already treated you, sought payment, or performed health 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 operations, but as directed in our Notice of Privacy Practices, we are not obligated to agree to these suggested restrictions. If we do agree, however, the restrictions are binding by us. Our Notice outlines how to ask for restrictions. In addition, if you fill out a form requesting that we fax your records to another provider, we are not accountable for errors resulting in your records being received by a wrong third-party. In the event that such a faxing error shall occur, Jamesburg Family Eyecare shall be absolved of all liability.

Patient's Name:__________________Patient'sDOB:_______________________
Responsible Party's
Name:_____________________________Date:______________________________
Responsible Party's
Signature:______________________________Witness:_______________________