

FLEETWOOD OPHTHALMOLOGY

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PATIENT CONSENT FORM

I understand that under the Health Insurance Portability and Accountability Act of 1996, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers.

Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy containing a more complete description of the uses and disclosures of my health information. I have been given the right to review your Notice of Privacy prior to signing this consent. I understand that the office of Seth A. Biser, M.D., P.C. can change its Notice of Privacy Practices from time to time and that I can contact your office to get a current copy.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment payment or health care operations. I also understand you are not required to agree to my requested restrictions but if you do agree then you must abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient's Name _____

Signature _____

Date _____

If signer is not patient,
Name and Relationship to Patient _____