PATIENT INFORMATION FORM

DR. LELAND BARRY
FAMILY EYECARE CENTER
651 EAST PARK AVENUE
LONG BEACH, N.Y. 11561

INDIVIDUAL CONSENT

CONSENT TO USE OR DISCLOSE YOUR HEALTH INFORMATION FOR **TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS**

_____

PATIENT NAME

In providing service to you, we create and store health information that identifies you. We understand that this information about you and your health is personal and we are committed to protecting the privacy of this information. We must obtain your one-time written consent before we treat you, obtain payment for our services, and conduct pre/post-operative care at your office. *Please read carefully the information below before signing this form.*

Notice of Privacy Practices. We have a comprehensive Notice of Privacy Practices that describes these uses and disclosures in detail and we encourage you to read it. We want you to know, however, that the Notice of Privacy Practices is subject to change. If you want to know when it is changed, please notify one of our staff members so that we could contact you with any changes.
Revoking Consent. You have the right to revoke this consent at any time, except to the extent that the center has already taken action based upon you consent. For example, if you revoke your consent after we have provided you with treatment, the office will be permitted to use or disclose your protected health information to bill for that treatment. To revoke this consent, please write to our office.
Scope of Consent. *By signing this consent form, I hereby authorize Dr. Leland Barry to use and disclose any personal health information as necessary for the purposes of obtaining medical treatment, facilitating the payments for such treatment and for normal business operations.*

_____ _____

Signature of Patient or Personal Representative **Date**

_____ _____

Print Name of Personal Representative **Relationship to Patient**

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By initialing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices and have therefore, been advised of how certain health information about me may be used and disclosed by Dr. Leland Barry and how I may obtain access to and control this information.

Initial ( ) I received/was offered a copy of the Notice of Privacy Practices Notice of Privacy Practices Version Number