OPHTHALMIC PLASTIC SURGERY, PLLC
Patient Consent for Use and Disclosure
Of Protected Health Information

With my consent, Ophthalmic Plastic Surgery of Albany may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Ophthalmic Plastic Surgery of Albany Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Ophthalmic Plastic Surgery of Albany reserves the right to revise its Notice of Privacy Practices at anytime.

With my consent, Ophthalmic Plastic Surgery of Albany may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations (TPO), such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Ophthalmic Plastic Surgery of Albany may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With my consent, Ophthalmic Plastic Surgery of Albany may photograph me for medical documentation of my condition, treatment, payment and healthcare operations. (TPO)

I have the right to request that Ophthalmic Plastic Surgery of Albany restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Ophthalmic Plastic Surgery of Albany's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Ophthalmic Plastic Surgery of Albany may decline to provide treatment to me.

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Signature of Patient or Legal Guardian Date

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Print Name of Patient or Legal Guardian