Consent for Purposes of Treatment, Payment and Healthcare Operations

Patient Name_____

I consent to the use or disclosure of my protected health information by Dr. James L. Simonson, O.D., Inc. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of the medical practice. I understand that diagnosis or treatment of me by Dr. James L. Simonson, O.D., Inc. may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the medical practice. Dr. James L. Simonson, O.D., Inc.is not required to agree to the restrictions that I may request. However, if the medical practice agrees to a restriction that I request, the restriction is binding on Dr. James L. Simonson, O.D., Inc. and employees

I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. James L. Simonson, O.D., Inc . has taken action in reliance on this consent. Otherwise, this consent is good for a period not to exceed 6 years from the date signed.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Dr. James L. Simonson, O.D., Inc . Notice of Privacy Practices prior to signing this document. The medical practice's Notice of Privacy Practices will be provided to me to review, if requested. The Notice of Privacy Practices describes in more detail the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Dr. James L. Simonson, O.D., Inc. The Notice of Privacy Practices for Dr. James L. Simonson, O.D., Inc. is also posted in the medical office waiting area. The Notice of Privacy Practices also describes my rights and the Dr. James L. Simonson, O.D., Inc.'s duties with respect to my protected health information.

Dr. James L. Simonson, O.D., Inc . reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment. **Any questions regarding this document or the Notice Of Privacy Practices should be directed to our Privacy Officer- Amber Moffitt at (661) 765-4270.**

_____ _____

Signature of Patient or Personal Representative Office Representative Signature

_____

Print Name of Patient or Personal Representative

_____ _____Restriction Requested

Date _____No Restrictions

_____

Relationship to Patient

I_____ request the following restrictions on the use and/or disclosure of my protected health information:

List specific restrictions desired:

_____
_____
_____
_____
_____
_____

This restriction will be enforced until terminated by me or the consent expires in 6 years.

_____ _____

Patient Signature Date

_____

Patient Representative Signature

_____

Office Representative Signature of receipt of restriction