WATERTOWN EYE CENTER / CENTER FOR SIGHT

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations.

I, ____________________________________ understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that Watertown Eye Center / Center For Sight preserves the right to change its notice and practices and, prior to implementation, will post a copy of revised changes. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that Watertown Eye Center / Center For Sight is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that Watertown Eye Center / Center For Sight has already taken actions in reliance thereon.

I wish to have the following restrictions to the use or disclosure of my health information:

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I understand and **accept / decline** the terms of this consent.

____
Patient Name (printed)

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Patient Signature

____
Date