Account #_____

Athens Eye Doctors & Surgeons, LLC
Patient Consent For Use and Disclosure
Of Protected Health Information

I hereby give my consent for Athens Eye Doctors & Surgeons, LLC to use and disclose my protected health information (PHI) to carry out treatment, payment and healthcare operations (TPO).

Athens Eye Doctors & Surgeons, LLC Notice of Privacy Practices provides 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.

Athens Eye Doctors & Surgeons, LLC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to HIPAA Coordinator at 105 Trinity Place, Athens, GA 30607.

With this consent, Athens Eye Doctors & Surgeons, LLC may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Athens Eye Doctors & Surgeons, LLC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, Athens Eye Doctors & Surgeons, LLC may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that Athens Eye Doctors & Surgeons, LLC restrict how it uses or discloses my PHI to carry out TPO pursuant to the HIPAA Omnibus Rule of 2013.

By signing this form, I am consenting to Athens Eye Doctors & Surgeons, LLC's use and disclosure of my PHI to carry out TPO and I am acknowledging the Notice of Privacy Practices.

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, or later revoke it, Athens Eye Doctors & Surgeons, LLC may decline to provide treatment to me.

I permit Athens Eye Doctors & Surgeons, LLC to release my PHI to: _____

_____

_____

Please list names (Example: spouse, parent, child, etc.)

X_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Patient's Name Print Name of Patient or Legal Guardian

_____
Patient's Date of Birth