Retina Consultants of Boston
Practice Name

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Retina Consultants of Boston (Practice Name) to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

(Retina Consultants of Boston (Practice Name) Notice of Privacy Practices provides a more complex description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent.

Retina Consultants of Boston (Practice Name) reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Retina Consultants of Boston (Practice Name) Privacy Officer at 39 Cross St., Suite 201, Peabody, MA 01960

With this consent, Retina Consultants of Boston (Practice Name) 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, Retina Consultants of Boston (Practice Name) 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 as long as they are marked Personal and Confidential.

With this consent, Retina Consultants of Boston (Practice Name) 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 Retina Consultants of Boston (Practice Name) 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 Retina Consultants of Boston's use and disclosure of my PHI to carry out TPO.

Practice Name

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, Retina Consultants of Boston may decline to provide treatment to me.

Practice Name

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Signature of Patient or Legal Guardian

_____ _____

Patient's Name Date

_____

Print Name of Patient or Legal Guardian