

**Patient Consent to the Use and Disclosure of Health Information  
For Treatment, Payment, or Healthcare Operations**

I, \_\_\_\_\_, understand that as part of my health care, Deborah A Thomas O.D. & Associates originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

**Our Privacy Principles:**

- The privacy of your health information is important to us.
- We maintain physical, electronic, and procedural safeguards that comply with federal regulations to protect your health information.
- We do not share your health information unless permitted or required by law for treatment, payment, or health care operations, or unless you authorize it.

I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Deborah A Thomas O.D. & Associates is not required to agree to the additional restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

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

**I prefer to be contacted in the following manner (check all that apply):**

- |  |  |
|--|--|
| <input type="checkbox"/> Home Telephone _____<br><input type="checkbox"/> OK to leave message with detailed information<br><input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> Written Communication:<br><input type="checkbox"/> OK to mail to home address<br><input type="checkbox"/> OK to e-mail _____<br><input type="checkbox"/> OK to fax to _____ |
| <input type="checkbox"/> Work Telephone _____<br><input type="checkbox"/> OK to leave message with detailed information<br><input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> Cell Phone _____<br><input type="checkbox"/> OK to text message<br>(example: Appt information)  |

I DO authorize the release of prescription information / materials to family members or the following persons: Name(s) \_\_\_\_\_

or

I do NOT authorize the release of prescription information / materials to family members.

I understand and have been provided with an opportunity to review the *Notice of Privacy Policies* that provides a more complete description of information uses and disclosures.

\_\_\_\_\_  
**Patient's Signature**

\_\_\_\_\_  
**Date**

**FOR OFFICE USE ONLY**

- [ ] Consent received by \_\_\_\_\_ on \_\_\_\_\_
- [ ] Consent refused by patient, and treatment refused as permitted.
- [ ] Consent added to the patient's medical record on \_\_\_\_\_