Authorization Rule HIPAA Privacy of Patient Agreement

I, _________________________, (patient's name) understand that as part of my healthcare, Toluca Lake Optometric Center 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 health care professionals who may contribute to my healthcare;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party can verify that services billed were actually provided;
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I have been provided a copy of the **Notice of Privacy Practices** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Heath Information (PHI) to another covered entity. I have the right to review Toluca Lake Optometric Center's Notice of Privacy Practices prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (164.506(a))

I understand that:

- I have the right to review Toluca Lake Optometric Center's Notice of Information practices prior to signing this consent;
- Toluca Lake Optometric Center, reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised to the address I've provided if requested;
- I have the right to request restrictions as to how my PHI may be used or disclosed to carry out treatment, payment, or healthcare operations and that Toluca Lake Optometric Center is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that Toluca Lake Optometric Center, has already taken action in reliance thereon.
- It is Toluca Lake Optometric Center's procedure to share PHI with labs, consulting physicians, and hospitals. We will communicate with the pharmacy of your choice regarding your prescriptions. We will only exchange the minimum necessary PHI for each transaction.

Print Name of Patient or Legal Representative____

Signature of Patient or Legal Representative____

Date_________________________________