New 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, Selma Family Practice Optometry, Inc., DBA Eyemax Vision Center originates and maintains paper and electronic records. These records describe my health history, symptoms, examination, test results, diagnosis, treatment plans, and future care or treatment plans. 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 knowledge to my bill. A means by which a third-party payer can verify that services billed were provided. A tool for routine health care operations, such as assessing quality and reviewing the competence of health care professionals.

I understand and have been provided with a Notice of Information Practices that provides a complete description of information uses and disclosures. I know that I have the following rights and privileges:

I have the right to review the notice before signing this consent—the right to object to using my health information for directory purposes. I have the right to request restrictions on how my health information may be used or disclosed to effect treatment, payment, or health care operations.

I understand that Rheumatology Associates is not required to agree to the restrictions requested. I know that I may revoke this consent in writing, except that the organization has already taken action in reliance thereon. I also understand that by refusing to sign or withdraw this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I understand that Selma Family Practice Optometry, Inc. reserves the right to change its notice and practices before implementation under Section 164.520 of the Code of Federal Regulations. Should Rheumatology Associates change their information, they will send a copy of any revised notice to the address I have provided.

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

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I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity. I consent to such disclosure for these permitted uses, including via fax.

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

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Patient's Signature Date