STRECKER EYE CENTER

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTION HEALTH INFORMATION

I hereby give my consent to Strecker Eye Center to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Strecker Eye Center's notice of privacy practices provides a more complete description of such uses and disclosure.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Strecker Eye Center reserves the right to revise its Notice of Privacy Practices anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Strecker Eye Center Privacy officer at 751 CJC HWY Cohasset, MA 02025.

With this consent, Strecker Eye Center may call my home or other alternative location and leave a message or voicemail or in person in reference to any items that assist the practice in carrying out TPO. This may include appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results among others.

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

With this consent, Strecker Eye Center may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request that Strecker Eye Center 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 Strecker Eye Center's use and disclosure of my PHI to carry out TPO.

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 evoke it, Strecker Eye Center may decline to provide treatment to me.

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Signature of patient or legal guardian

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Patient's Name Date

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Print name of patient or legal guardian