THE REEVES EYE INSTITUTE

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations.

I understand that as part of my healthcare, The Reeves Eye Institute originates and maintains health records describing my health history, symptoms, examinations, test results, diagnoses, treatment, and plans for future treatment and care. I understand that this information serves as:

*A means of communications among the many health professionals who contribute to my care
*A basis for planning my care and treatment
*A source of information for applying my diagnosis and surgical information to my bill
*A means by which a third-party payer can verify that services bill were provided
*A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that I have been provided with a NOTICE OF PRIVACY PRACTICES that provides a complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the Reeves Eye Institute reserves the right to change its notices and practices. I understand that I have the right to request restrictions as to how my healthcare may be used and disclosed to carry out treatment, healthcare operations or payment and The Reeves Eye Institute is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.
I authorize The Reeves Eye Institute to leave messages for me regarding my care via the avenues I have initialed below. In the event that I do not speak directly with a representative of The Reeves Eye Institute, they may send me appointment postcard reminders. I also give my consent for messages to be left in the following manner(check all that apply):

□ home phone _____ □cell phone _____
□ work phone _____ □email _____
□ other person(s) Please specify name(s) _____

_____

_____ _____
Signature of Patient or Legal Representative Date