VISION INSTITUTE--VISION INSTITUTE OPTICAL (VI-VIO)

A single affiliated covered entity as defined in 45 CFR §164.504(d)

PATIENT CONSENT

PATIENT NAME: _____ **Patient Account Number:** _____

Physicians and health care providers, including VI-VIO, have always protected the confidentiality of your protected health information under the "doctor-patient" privilege and have refused to provide this information without your permission, unless otherwise permitted by law. Federal law has added certain legal protections through privacy rules, including requirements for written consent.

I. CONSENT TO USES OF PROTECTED HEALTH INFORMATION (45 CFR §164.506):

Protected Health Information (PHI) is health information about you, including demographic information, that has been collected from you and created or received by your physician, VI-VIO, other health care providers, health plans, employers, or a health care clearing house. PHI relates to your past, present or future physical health or mental health or conditions. In addition, PHI must be directly identified to you or have a reasonable basis for belief that the information pertains to you. (45 CFR §164.506(c)(1)).

I hereby consent to the use and disclosure of my PHI by VI-VIO for the purposes of diagnosing my physical condition, providing health treatment to me, obtaining payment for my health care bills, and conduction health care operations by VI-VIO. (45 CFR §164.506(a)):

I understand that if I do not sign this consent concerning PHI, VI-VIO may decline to provide treatment to me unless it is an emergency. (45 CFR §164.506(b)(1).

I also understand that I have the right to request a restriction on how VI-VIO uses or discloses my PHI in carrying out my diagnosis, treatment, payment for services or healthcare operations, but that VI-VIO is not required to agree to my restrictions. However, if VI-VIO agrees to a restriction, the restriction is binding on VI-VIO. (45 CFR §164.506(c)(4))

I further understand that I have a right to review VI-VIO's Notice of Privacy Practices before signing this consent form. The Notice of Privacy Practices describes the types of uses and disclosures of my PHI that will occur during my diagnosis, treatment, payment of bills and in the performance of health care operations. It also describes my rights and duties concerning PHI. VI-VIO reserves the right to change its privacy practices and if it does so, I will be able to obtain a copy of the revised practices by asking our front desk personnel. Copies of the current Notice of Privacy Practices are available in the waiting room or from the front desk personnel. I acknowledge that the Notice of Privacy Practices has been made available to me. (45 CFR §164.506(c)(2) & (3)).

I further understand that I have the right to revoke this consent in writing at any time, except to the extent that VI-VIO has acted in reliance upon this consent. (45 CFR §164.506(c)(5)). This consent and associated documentation will be retained for a period of six years after revocation or last use. (45 CFR §164.530(j)):

Signature: _____ Date: _____
Patient or Patient's Personal Representative

Printed Name: _____ Capacity of Personal Representative: _____

II. GENERAL CONSENT TO TREATMENT AND ASSIGNMENT OF BENEFITS (45 CFR §164.506(b)(4)):

I hereby consent to the general professional medical and vision care to be provided by VI-VIO during routine office visits. I understand and acknowledge that prior to any medical procedure or surgical care, I will be provided specific information concerning the procedure or surgery an will be requested to sign an informed consent form for that procedure or surgery. I assign the payment of benefits payable for physician/medical services to VI-VIO and authorize VI-VIO to submit a claim and receive payment directly to VI-VIO for any benefits due for its services.

Signature: _____ Date: _____
Patient or Patient's Personal Representative

Printed Name: _____ Capacity of Personal Representative: _____

REVOCATION: The Consent in Part I above is REVOKED this date: _____ effective upon receipt by VI-VIO.

Signature: _____ Date: _____
Patient or Patient's Personal Representative

Printed Name: _____ Capacity of Personal Representative: _____

FOR OFFICE USE ONLY: Date Received: _____ By: _____