CONSENT TO USE OR DISCLOSE HEALTH INFORMATION for treatment, payment, & healthcare operations

307 Vision

Patient Name: _____

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this information in order to treat you, to obtain payment for these services, and to conduct health care operations involving our office.

We have a Notice of Privacy Practices that describes these uses and disclosures in detail. You are free to refer to this Notice at any time before you sign this consent document.

When you sign this consent document, you signify that you agree we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perform health care operations. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use your health information in accordance with this consent.

I HAVE READ THIS CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

_____ _____

Date Patient's Signature

If you are signing as a personal representative of the patient, describe your relationship to the patient.

_____ _____

Relationship to Patient Signed:

Ph: (307) 266-9988

3400 E. 2nd Street
Casper, WY 82609

Fax: (307) 266-9992