Jannelle Cuddy, OD

Hallmark Opticians
1911 NE Broadway * Portland, OR 97232 * (503) 288 – 5719

Consent to Use or Disclose Clinical Information

I authorize Jannelle Cuddy, OD to use and disclose the health and clinical information of:

____
(**printed** name of patient)

for the purpose of Treatment[1], Payment[2] and Health Care Operations[3] .

I understand that I should review the NOTICE OF PRIVACY PRACTICES OF Jannelle Cuddy, OD for the additional information about the uses and disclosures of information, described in the CONSENT, prior to signing the CONSENT.

Because Jannelle Cuddy, OD reserves the right to change her PRIVACY PRACTICES in accordance with the HIPPA PRIVACY RULES, the terms contained in the NOTICE OF PRIVACY PRACTICES may also change. A summary of the NOTICE OF PRIVACY PRACTICES is on the wall at the entrance to the examination room. Jannelle Cuddy, OD or her staff will offer me a copy of the NOTICE OF PRIVACY PRACTICES on my first visit to his office after the effective date of the current NOTICE OF PRIVACY PRACTICES. I will be given a copy at my request.

As more fully explained in the NOTICE OF PRIVACY PRACTICES, I have the right to request restrictions on how my protected health information may be used and disclosed for treatment, payment and health care operations *Jannelle Cuddy, OD is not required to agree to my request. If* she agrees, Jannelle Cuddy, OD is required to comply with my request unless the information is needed to provide emergency treatment to me. Other practitioners who provide coverage for Jannelle Cuddy, OD's practice are required to use and disclose my protected health information with the NOTICE OF PRIVACY PRACTICES.

I hereby verify that I have been offered a copy of Jannelle Cuddy, OD's NOTICE OF PRIVACY PRACTICES by signing my initials here ______________.

I understand that I have the right to revoke this CONSENT provided that I do so *IN WRITING*, except to the extent that Jannelle Cuddy, OD has already used or disclosed the information in reliance on this CONSENT.

Patient Signature ____ Date _______________

Guardian or Legal Rep. Sign. _______________________________ Date _______________

Indicate the nature of your relationship with the patient: _______________________________

1. TREATMENT includes activities performed by Jannelle Cuddy, OD to: provide care to you, coordinate or manage your care with third parties and consult with and between other health care professionals. This consent includes treatment provided by any professional who covers this practice as an on-call professional.
2. PAYMENT includes uses and disclosures required to determine your eligibility for health plan coverage or to bill and receive payment for your health care benefit claims, and any health plan management activities, which may include review of your services for clinical necessity, justification of charges, precertification and preauthorization.
3. HEALTH CARE OPERATIONS includes the administrative and business functions of this practice.