CENTER FOR SIGHT

CENTER FOR SIGHT, P.L., SURGICAL SERVICES AT CENTER FOR SIGHT, LLC & MONTGOMERY EYE CENTER, INC (CFS)
PATIENT ACKNOWLEDGEMENT AND AUTHORIZATION

Patient Name: _____ Patient Medical Record #: _____

Consent to Use and Disclose PHI & Acknowledgement of Receipt of Notice of Privacy Practices:
General consent to use and disclose personal health information to carry out treatment, payment for treatment and health care operations.

With my signature below, I give CFS permission to disclose my personal health information as necessary to carry out treatment, obtain payment for treatment provided to me and to carry out its health care operations.

A complete description of how CFS will use and disclose my personal health care information can be found in its Notice of Privacy Practices which has been made available to me.

I have the right to review the Notice of Privacy Practices prior to signing this consent. I understand that the Notice of Privacy Practices may be revised at any time by CFS and that I may view changes to the Notice of Privacy Practices at their website at www.CenterForSight.net or by requesting a printed copy of revision from the Compliance department in writing. I hereby acknowledge that I have received, and have had the opportunity to ask questions regarding, a copy of the CFS Notice of Privacy Practices.

I have the right to request restrictions regarding how my personal health information is used or disclosed in the course of carrying out treatment, obtaining payment for treatment provided to me and carrying out health care operations. I may request restrictions by filling out the appropriate form which will be provided to me upon request. CFS is under no obligation to implement any of the restrictions that I may request but will be bound by any restrictions that it agrees to implement.

I understand that I may revoke this consent at any time notifying CFS in writing, except to the extent that action has been take in reliance on it.

Patient's / Patient's Legal Representative Signature: _____ **Date:** _____

If signed by Representative, state relationship to patient: _____

Authorization to Release Protected Health Information (PHI):
I hereby authorize CFS to release my PHI to the following person(s) and understand that I may revoke this authorization in writing at any time. I understand that such disclosures may include, but not be limited to, discussing my medical condition(s) and treatment(s) with individuals that accompany me to my appointments and / or are responsible for my care-giving, leaving voice mail messages regarding appointments and / or balances due on my account, and any emergency situation which may arise in the course of my care.

Name of Authorized Person	Relationship	Daytime Phone Number

Emergency Contact Information (To be completed if different from above):
I hereby authorize CFS to contact the following person in any emergency which may arise in the course of my care.

Name of Authorized Person	Relationship	Daytime Phone Number

Patient's / Patient's Legal Representative Signature: _____ **Date:** _____

If signed by Representative, state relationship to patient: _____

Documentation of Good Faith Efforts (To be completed if patient unable or unwilling to sign above):
On this day, patient presented for treatment and was provided a copy of the CFS's Notice of Privacy Practices. Although a good faith attempt was made to obtain a written Acknowledgement of Receipt and Authorization to Release, signatures were not obtained because:

_____ Patient / Legal Representative refused
_____ Patient / Legal Representative unable due to medical disability
_____ Emergency medical condition required immediate attention (signature to be obtained at next appointment)

Printed Name of CFS Employee: _____

Signature of CFS Employee: _____ **Date:** _____

Internal Use Only