Christopherson Eye Clinic

CONSENT TO ARRANGE FOR PAYMENT AND FOR SHARING OF MY INFORMATION

Your privacy is important. If you don't understand this form, ask questions. We cannot accept changes to this form.

My consent to sharing (release) of my information

- **For treatment**: I authorize you, as my provider, to share my information with other healthcare professionals and facilities for treatment purposes, such as managing or coordinating care, and related services.
- **For payment**: I authorize you, as my provider, to share my information with my health plan and others as needed for payment purposes, such as eligibility and coverage determinations, billing, processing claims, coordinating benefits, utilization review, and related functions, including those functions that you, as my provider, are required by my health plan or other third-party payers to perform.
- **To run your organization (health care operations):** I authorize you, as my provider, to share my information with others to improve the quality of my care and experience, and to manage your business operations. This includes activities such as licensing and accreditation, and evaluating quality.
- **Health plan information**: I authorize my health plans to share my information (about services I have received) with you, as my provider, and with other healthcare professionals and facilities from whom I receive health care, as needed for treatment, management and coordination of my care, accreditations and quality review/measurement.

My responsibility for payment and assignment of benefits

- **I authorize you**, as my provider, to bill my health plans (including Medicare/Medicaid and other third party payers), directly on my behalf, so that you will receive direct payment of authorized benefits.

My signature and acknowledgement

My consent will be valid for six years from the date I give it. I may revoke my consent to share my information, in writing, at any time. Revoking my consent doesn't apply to information that has already been shared. I understand that some uses and sharing of my information are authorized by law and do not require my consent.

For the purposes of my consent, "provider" means the Christopherson Eye Clinic. "My information" means information that identifies me and relates to my health and services received, as explained in more detail in the Notice Of Privacy Practices.

My provider's Notice of Privacy practices has been made available to me. It describes my privacy rights and additional disclosures the provider may make according to law.

_____ _____

Print Patient Name Today's Date

_____ _____

Signature of patient or authorized representative Patient Date of Birth

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Reason Patient is Unable to Sign