Greenspan Family Eyecare
1259 Route 46 East, Bldg. 4B
Parsippany, NJ 07054-4708
Phone: 973-263-9400
Fax: 973-263-3376

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION

I understand that this organization originates and maintains health records, which describe my health, history, symptoms, examination, test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information is used to:

- Plan my care and treatment
- Communicate among health professionals who contribute to my care
- Apply my diagnosis and services, procedures, and surgical information to my bill
- Verify services billed by third-party payers
- Assess quality of care and review the competence of healthcare professionals in routine healthcare operations

I further understand that:

- A complete description of information uses and disclosures is included in a *Notice of Information Practices* which has been provided to me
- I have a right to review the notice prior to signing this consent
- The organization reserves the right to change their notice and practices
- Any revised notice will be mailed to the address I have provided prior to implementation
- I have the right to object to the use of my health information for directory purposes
- I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations
- The organization is not required to agree to the restrictions requested
- I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I give my permission for the following person(s) to acquire copies of my health records and billing information

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____
Printed Name of Patient or Legal Representative

____ ___________________
Signature of Patient or Legal Representative Date

Office Use Only:
______ Accepted _______Rejected
_______________Initials _____________________Date