Authorization for Use and Disclosure of Protected Health Information

By signing this authorization, I authorize Chautauqua EyeCare to use and/or disclose certain protected health information (PHI) about me to carry out treatment, payment, & healthcare operations (TPO). This authorization permits Chautauqua EyeCare to use/and or disclose individually identifiable health information about me. Chautauqua EyeCare's Notice of Privacy Practices provides a more complete description of such uses & disclosures. I have opted to (receive/not receive) the Notice of Privacy Practices prior to signing this consent. This information will be used or disclosed for TPO purposes or at my request. The purposes are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire 6 years from the date of signature.

I do not have to sign this authorization to receive treatment from Chautauqua EyeCare. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed, pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the Practice has acted in reliance upon this authorization. My written revocation must be submitted to:
Chautauqua EyeCare, 168 North Union St, Olean, NY 14760, 716-372-9464.

Patient Signature : X _____
(or Parent/Legal Guardian)

I understand my signature requests that payment be made and authorizes release of information necessary to pay a claim directly to Chautauqua EyeCare. Chautauqua EyeCare accepts the charge determination of participating insurance carriers & I am responsible only for the deductible, co-insurance, & non-covered services. I agree to obtain necessary healthcare plan referrals, or I am obligated to pay for such services.
I agree that in return for services provided by Chautauqua EyeCare, I will pay my account at the time services are rendered or will make financial arrangements satisfactory to Chautauqua EyeCare for payment. I understand that glasses are a made to order item and there may be a restocking fee associated with any return. I understand any changes must be addressed within 30 days of notification that my order is complete. If an account is sent to an attorney for collection, I agree to pay collection expenses & reasonable attorney's fees as established by the Court and not by Jury in any Court action. I understand & agree that if my account is delinquent, I may be charged interest at the legal rate. Benefits of any type under any insurance policy ensuring the patient or any other party liable to the patient is hereby assigned to Chautauqua EyeCare. I agree to make co-payments and/or deductible(s) designated by my insurance company or health plan to Chautauqua EyeCare. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

Patient Signature : X _____
(or Parent/Legal Guardian)

_____ _____
Printed name of Patient (Printed name of Parent/Legal Guardian, if applicable)

Chautauqua EyeCare has my permission to send me appointment or health insurance information by: Mail and Phone.
Chautauqua EyeCare has my permission to upload my current medications from my pharmacy.

Patient Signature : X _____
(or Parent/Legal Guardian)

Date: _____