

Chico Eye Center
605 W East Ave
Chico CA 95926

Chico Eye Center
6585 Clark Rd, #340
Paradise, CA 95969

HIPAA Consent Form

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to allow **Chico Eye Center** to use or disclose my protected health information for treatment, payment and health care operations.

- Treatment means the provision, coordination, or management of health care and related services by one or more health care providers.
- Payment means the activities undertaken by a health care provider or health plan to obtain or provide reimbursement for the provision of health care.
- Health care operations means conducting quality assessment, reviewing the competence or qualifications of the health care professionals; medical reviews; legal services; and auditing functions; of **Chico Eye Center**.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **Chico Eye Center** is not required to agree to the restrictions that I may request. However, if **Chico Eye Center** agrees to a restriction that I request, the restriction is binding on **Chico Eye Center**, and their physicians.

I have the right to revoke this consent, in writing, at any time, except to the extent that **Chico Eye Center** has taken action in reliance on this consent.

I understand I have a right to review **Chico Eye Center's** Notice of Privacy Practices prior to signing this document. The **Chico Eye Center's** Notice of Privacy Practices will be provided to me upon request. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, and payment of my bills for **Chico Eye Center**. The Notice of Privacy Practices for **Chico Eye Center** can be obtained at the check in desk. This Notice of Privacy Practices also describes my rights and the **Chico Eye Center's** duties with respect to my protected health information.

Chico Eye Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Name of patient _____
(Please Print)

Signature of Patient or (Guardian)

Relationship to Patient

Date _____