



Ocular Surface Center

Practice Exclusively Specialized in Difficult Ocular Surface Diseases
Scheffer C.G. Tseng, M.D., Ph.D.

[NOTE: use of this form is optional]

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent.

This Consent was signed by: _____
Printed Name – Patient or Representative

Relationship to Patient (if other than patient): _____

Date: _____ / /

In front of _____
Printed name – Practice representative



**AUTHORIZATION FORM
FOR OTHER USES OF PROTECTED HEALTH INFORMATION**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you pursuant to our general Patient Consent Form. On occasion, the patient and the Practice may want to use PHI for reasons other than treatment, payment, and health care operations. This form summarizes the anticipated use of information about you for which this authorization is required. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Specific description of the information to be used or disclosed, including the specific purpose:

Individuals who may use or disclose this information: _____

Individuals who may receive and use the disclosed information: _____

Expiration date of this authorization: _____

The above mentioned protected health information may be subject to re-disclosure by the party receiving the information and may no longer be protected by the privacy rules.

By signing this form, you authorize the Practice to use and disclosure protected health information about you for the reasons mentioned above. You have the right to revoke this authorization at any time, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior authorization. Submit your revocation to the Privacy Officer of the Practice.

This authorization was signed by: _____
Printed Name – Patient or Representative

In front of _____
Printed name – Practice representative

Witness: _____ / / _____
Name Date Patient or Representative

Relationship to Patient (if other than patient): _____

Date: _____ / / _____



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REQUEST FOR ACCESS TO MEDICAL INFORMATION

Our Notice of Privacy Practices provides information about our use of a patient's protected health information. The Notice contains a Patient Rights section describing your rights under the law. Patients have the right to access, inspect, and copy protected health care information used to make decisions about them.

The Practice will only include information used to make decisions about the patient. The Practice may limit access to information generated only by this Practice. Under some circumstances, such as increased risk of harm or injury, the Practice may withhold the requested information. The Privacy Officer of this Practice will evaluate this Request and notify the patient of our decision within fifteen (15) days of this Request. If the Request is approved, the Practice will provide the information within thirty (30) days, or within sixty (60) days if such an extension is necessary. Reasonable costs will be charged for the Request. Costs will be submitted to the patient upon approval of the Request. The Practice may provide a summary of the requested information if you are agreeable.

The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Patient Name: _____

Health Care Information requested. Please provide dates, diagnosis, treatment, or any other indications of the specific information you desire: _____

Is a summary of the information acceptable? _____

Do you wish to:

- Arrange an appointment to inspect the requested information?
- Receive a copy of the information?

Instructions regarding copies.

I will pick the copies

Please mail the copies to me at the following address: _____

This Request was signed by: _____

Printed Name – Patient or Representative

Relationship to Patient (if other than patient): _____

Date: _____ / ____ / ____