Macular Research Institute

Retina & Vitreous CENTER PC

William S. Rodden, M.D.
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Patient Name (PLEASE PRINT): _____ Date of Birth: _____

ACKNOWLEDGEMENT OF HIPAA PRIVACY INFORMATION

The Retina & Vitreous Center of Southern Oregon, PC's "**Notice of Privacy Practices**" contains information about the uses and disclosures of your protected health information.

Because we reserve the right to change our privacy practices in accordance with the law, the terms contained in the **Notice** may also change. An updated **Notice** will be posted in the lobby of our office indicating the effective date of the Notice in the lower right-hand corner. You will be offered a copy of the updated **Notice** on your first visit to our office after the effective date of the updated **Notice**. We will also provide you with a copy of the **Notice** upon your request.

I have reviewed the Retina & Vitreous Center of Southern Oregon, PC's **Notice of Privacy Practices**, and a copy of the **Notice** has been made available to me.

CONSENT TO USE OR DISCLOSE MEDICAL INFORMATION

As more fully explained in the above **Notice**, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment and health care operations purposes. ***We are not required to agree to your request.*** If we do agree, we are required to comply with your request, unless the information is needed to provide you with emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the **Notice**.

I authorize the Retina & Vitreous Center of Southern Oregon, PC to use and disclose my health and medical information for the purposes of <u>treatment, payment, and health care operations</u>.

I understand that I have the right to revoke this **Consent** provided I do so **<u>in writing</u>**, except to the extent that Retina & Vitreous Center of Southern Oregon, PC has already used or disclosed the information in reliance on this **Consent**.

Please check the appropriate box below

☐ I agree to the above consent to use or disclose medical information

Patient Signature **Date**

OR

Person Authorized by Law (PLEASE PRINT) | Signature / Relationship to Patient | Date

☐ I decline to consent to use or disclose medical information. In doing so, I understand that Retina & Vitreous Center of Southern Oregon, PC will be unable to bill my insurance and I will be considered a self-pay patient; balance due at time of service. _____ (Patient initial here)

Patient Signature **Date**

OR

Person Authorized by Law (PLEASE PRINT) | Signature / Relationship to Patient | Date