Patient Authorization for Use and Disclosure Of Protected Health Information

By signing this authorization I authorize Allegany Eye Associates to use and/or disclose certain protected health information (PHI) about me to carry out treatment, payment & healthcare operations (TPO). This authorization permits Allegany Eye Associates to use and/or disclose individually identifiable health information about me. Allegany Eye Associate'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. The Practice may or may not receive remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Allegany Eye Associates. 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 as acted in reliance upon this authorization. My written revocation must be submitted to Eric Vossler, Privacy Officer, 12 Martin St, Wellsville, NY 14895, 585-593-6041.

Patient or Authorized Signature: _____

I understand my signature requests that payment be made and authorizes release of information necessary to pay a claim directly to Allegany Eye Associates. Allegany Eye Associates 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 Allegany Eye Associates, I will pay my account at the time services is rendered or will make financial arrangements satisfactory to Allegany Eye Associates for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses & reasonable attorney's fees as established 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 insuring the patient or any other party liable to the patient is hereby assigned to Allegany Eye Associates. I agree to make co-payments and/or deductible(s) designated by my insurance company or heath plan to Allegany Eye Associates. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

_____ _____

(Printed name of Patient) **(Signature of Patient or Legal Guardian)**

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(Printed name of Legal Guardian)

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

_____ _____

(Signature) **Date:**