Eye Physicians & Surgeons of Chicago, s.c.

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HIPAA CONSENT

Purpose of Use or Disclosure:
Your protected health information may be used and disclosed by our organization, our office team and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the organization, and any other use required by law.

Description of PHI to be Used or Disclosed:
We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party.
Your protected health information will be used, as needed to obtain payment for our health care services.
We may use or disclose, as-needed, your protected health information in order to support the business activities of our organization. These activities include, but are not limited to, quality assessment activities, employee review activities, accreditation activities, and conducting or arranging for other business activities.
We may use or disclose your protected health information in the following situations without your authorization as required by Law, Public Health issues as required by Law, communicable diseases, health oversight, abuse or neglect, Food and Drug Administration requirements, legal proceedings, law enforcement, criminal activity, inmates, military activity, national security and workers' compensation.
Required uses and disclosures: under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500

I understand that:
- I have the right to revoke this authorization at any time by providing written notice to Eye Physicians & Surgeons of Chicago, S.C., except to the extent that action has already been taken in reliance on this authorization.
- The information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.
- I have the right to refuse to sign this authorization and that my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be affected by my refusal to sign, except as required by law.

I, the undersigned, hereby authorize Eye Physicians & Surgeons of Chicago, S.C. and its affiliated healthcare providers to use and disclose my protected health information (PHI) as described above:

PATIENT NAME: _____ **PATIENT SIGNATURE:** _____

PATIENT DATE OF BIRTH: _____ **TODAY'S DATE:** _____