EASTSIDE EYE SURGEONS PLLC

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for EASTSIDE EYE SURGEONS PLLC to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. EASTSIDE EYE SURGEONS PLLC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by sending a written request to Mohamed Osman, Privacy Officer, 178 East 71 Street, NY 10021.

With this consent, EASTSIDE EYE SURGEONS PLLC may call my home or other location and may **leave a message on voicemail or answering machine or in person** in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and calls pertaining to my clinical care.

With this consent, EASTSIDE EYE SURGEONS PLLC may **mail to my home or other location** any items that assist the practice in carrying out TPO, such as reminders, billing statements and medical information.

With this consent, EASTSIDE EYE SURGEONS PLLC may **email to my personal/business email address** any items that assist the practice in carrying out TPO.

By signing this form, I m consenting to EASTSIDE EYE SURGEONS PLLC to use and disclosure of my PHI (Protected Health Information) to carry out TPO (Treatment, payment, operations).

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, **EASTSIDE EYE SURGEONS PLLC, MAY DECLINE TO PROVIDE TREATMENT TO ME.**

_____ _____

Signature of Patient Date

_____

PRINT Patient name