



**Authorization for the Use or Disclosure of Protected Health Information**

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
- The patient has been provided with a Grievance procedure

**Advance Directives: Statement of Limitation**

This facility does not provide implementation of advanced directives; on the basis of conscience (the scheduled procedure is an elective procedure), regardless of the contents of any advance directive or instructions from a health care surrogate or attorney. If an adverse event occurs at this facility, we will initiate resuscitative or other stabilizing measures and transfer patient to an acute care hospital for further evaluation. The receiving hospital will implement further treatment or withdrawal of treatment measures already begun in accordance with patient wishes, advance directive or health care power of attorney.

In accordance with Medicare’s Condition of Coverage for Ambulatory Surgical Centers, the following information has been provided to you, verbally and in writing, prior to procedure at the Surgery Center.

- Statement of Financial Interest: I was advised that Todd Ford, MD and Michael Blair, MD, maintain a financial interest in this Surgery Center.
- Statement of Patient’s Rights: A copy of the Patient’s Rights and Responsibilities and Grievance Procedure has been provided to me prior to the date of my initial procedure at this Center.

**Signature of Patient:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Assignment of Benefits**

I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, private insurance, or any other health plans to Paragon Laser & Eye Surgery Center. I hereby authorize said assignee to release all information necessary to secure payment. I understand Todd Ford, MD and Michael Blair, MD, maintain a financial interest in Paragon Laser & Eye Surgery Center.

I understand that I am financially responsible for all charges not paid by said insurance, including, but not limited to, non-covered services and cosmetic procedures.

A photocopy of this assignment is to be considered as valid as an original. This assignment will remain in effect until revoked by me in writing.

**Signature of Patient:** \_\_\_\_\_ **Date:** \_\_\_\_\_

PATIENT LABEL