Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by **Northwest Pediatric Ophthalmology** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me by **Northwest Pediatric Ophthalmology** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **Northwest Pediatric Ophthalmology** is not required to agree to the restrictions that I may request. However, if **Northwest Pediatric Ophthalmology** agrees to a restriction that I request, the restriction is binding.

I have the right to revoke this consent in writing, at any time, except to the extent that **Northwest Pediatric Ophthalmology** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review **Northwest Pediatric Ophthalmology** Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices will be provided to me on request. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations by **Northwest Pediatric Ophthalmology.** The Notice of Privacy Practices for **Northwest Pediatric Ophthalmology** practice is provided in a blue binder located in the waiting area. This Notice of Privacy Practices also describes my rights and **Northwest Pediatric Ophthalmology's** duties with respect to my protected health information.

Northwest Pediatric Ophthalmology reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent by fax, or asking for one at the time of my next appointment.

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Signature of Patient or Legal Guardian

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Name of Patient or Legal Guardian

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Date