Occu-Med
2230 Indianapolis Blvd,
Hammond, IN 46399
(219) 659 - 0333

Consent for Release and Use of Confidential Information and Receipt of Notice of Privacy Practices

I, _____, hereby giver my consent to Occu-Med to use of disclose for the purpose of carrying out treatment, payment or health care operations, all information contained in the patient record of _____ *(patient name).*

I also authorize my insurance company to pay directly to Occu-Med benefits due me out of the indemnity under the terms of my policy issued by my insurance company. I understand I am financially responsible for any uncovered, deductibles and co-payments.

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I authorize Occu-Med to release any and all records including but not limited to treatment and history of alcoholism/substance abuse, STD/HIV, psychiatric/psychological treatments, all labs, x-rays, reports in my records for the purpose of treatments, continuity of medical care, securing payments from third party payers and any legal matters.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the notice. I also understand that a copy of any revised notice will be provided to me and made available at my next office visit.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the practice. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

I wish to be contacted in the following manner (check all that apply):

- ☐ Home Telephone _____
  - ☐ OK to leave message with detailed information
  - ☐ Leave message with call back number only
- ☐ Work Telephone _____
  - ☐ OK to leave message with detailed information
  - ☐ Leave message with call back number only
- ☐ Written Communication
  - ☐ OK to mail to my home address
  - ☐ OK to mail to my work/office address
  - ☐ OK to fax to this number: _____
- ☐ Other _____

_____
Patient Signature *Date*

_____
Print Name *Birthdate*