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OPTOMETRISTS

**CONSENT TO USE OR DISCLOSE HEALTH INFORMATION FOR
TREATMENT, PAYMENT & HEALTH CARE OPERATIONS**

Patient Name _____

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office.

We have a comprehensive Notice of Privacy Practices that describes these uses & disclosures in detail. You are free to refer to this notice at any time before you sign this consent document. As described in our Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes not only includes care & services provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of information to a billing agent or vendor for processing claims or obtaining payment, our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; our submission of our health information to auditors hired by third-party payers and insurers, among other aspects of payment described in our Notice of Privacy Practices. Our Notice of Privacy Practices will be updated whenever our privacy practices change.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perform health care operations. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent. We can decline to serve you if elect not to sign this form.

You have the right to restrict the uses or disclosures made for purposes of treatment, payment, or health care operations, but as described in our Notice of Privacy Practices, we are not obligated to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our privacy practices describe how to request a restriction.

I HAVE READ THIS CONSENT & UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

Patient Signature

Date

If you are signing as a representative for the patient, describe your relationship to the patient and your source authority as an authorized signer.

Print Name and Source of Authority

Relationship to Patient