Patient Name:___________________

SKOLNICK EYE INSTITUTE
Patient Consent Form

Consent for Treatment

I voluntarily present to the Skolnick Eye Institute for medical evaluation, diagnosis, and/or treatment. I consent and authorize my provider(s) or his/her designee(s) to provide diagnostic and medical treatment which may be necessary or advisable in their professional judgment. By signing this consent form, I do not waive my right to refuse recommended tests or treatment.

_______________________________________ _________________________

Signature **Date**

Consent to Release Medical Information

In April of 2003, new federal requirements regarding privacy of information for health care patients took effect. HIPAA, the Health Insurance Portability and Accountability Act, requires that all medical providers, insurance companies and others, put in place controls to ensure that your personal medical information is safe.

Skolnick Eye Institute requests that each patient sign this consent form which allows us to share protected health information with other physician offices, your hospital and insurance company. 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, except where we have already made disclosures in reliance on your prior consent. Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent.

_______________________________________ __________________________

Signature **Date**

Authorization to Leave Messages with Household Members/Answering Machine

From time to time it is necessary for representatives of Skolnick Eye Institute to leave messages for patients. The purposes of these messages is to remind patients that they have an appointment, to notify the patient that the medical staff would like to discuss lab or procedure results, or to ask a patient to call the Skolnick Eye Institute regarding an issue or concern. At no time will a representative of the Skolnick Eye Institute discuss your medical circumstances or condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

_______________________________________ _________________________

Signature **Date**