Ophthalmology Assocaites
Jerry B. Cotner M.D.
Rishav Kansal M.D.

Consent for Use of Patient Information

This consent is for disclosure of protected health information for purpose of treatment, operations or payment.

I understand that Ophthalmology Associates may need to use and disclose information about my health or medical problems for the purposes of arranging, conducting, or referring for my treatments, for obtaining payment for the services rendered me and for the operations of the practice. I consent to the use of my information for the purposes of treatment, payment and health care operations.

I understand that my consent is not needed if the law requires Ophthalmology Associates to report some aspect of my protected health information to a government agency. Examples would include suspected abuse, communicable disease and potential for serious bodily harm to myself or others.

I understand that I have the right to review Ophthalmology Associate's privacy notice, to request restrictions on the use of my information and to revoke my consent at a later date.

I understand that if I withhold consent for the use of my information for the purposes of treatment, payment or operation, Ophthalmology Associates may decline to undertake my care.

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Signature

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Printed Name

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Date