Dr. Eddie Alan Smith
DOCTOR OF OPTOMETRY
The clear choice for expert vision care
617 South Main Street, Stillwater OK 74074
Office/ 405-372-7337 • Fax/ 405-372-7339 • web/ www.smitheyecare.com

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Dr. Eddie Alan Smith to use and disclose protected health information (PHI) about me to carry out treatment, continuing care, payment, and health care operations. (The Notice of Privacy Practices provided by Dr. Eddie Alan Smith describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Eddie Alan Smith reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

Dr. Eddie Alan Smith
617 South Main Street
Stillwater OK 74074

With this consent, Dr. Eddie Alan Smith may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out my care or continuing care, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, diagnosis, among others.

With this consent, Dr. Eddie Alan Smith may mail to my home or other alternative location any items that assist the practice in carrying out your care or continuing care, such as appointment reminders, diagnosis, and patient statements as long as they are marked "Personal and Confidential."

With this consent, Dr. Eddie Alan Smith may e-mail or text to my home or other alternative location any items that assist the practice in carrying out my care or continuing care, such as appointment reminders, diagnosis, and patient statements. I have the right to request that Dr. Eddie Alan Smith restrict how it uses or discloses my PHI to carry out my care and continuing care. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Dr. Eddie Alan Smith to use and disclose my PHI to carry out health care operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Dr. Eddie Alan Smith may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's Name Date

_____
Print Name of Patient or Legal Guardian, if applicable