McCullough Eyecare, PC
202 Walnut Street
Festus, MO 630289
Tel. (636)937-3130
Fax. (636)937-7202
Email: mcceyecare@sbcglobal.net
Web: www.mcculloughеyecare.com

HIPPA CONSENT

Patient Name:_____
Account No.:_____
Date:_____

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Permission to Use and Disclose My Health Information: By signing this form, I give McCullough Eyecare, PC permission to use and/or disclose my health information to provide treatment, obtain payment, and/or conduct health care operations.

Right to Refuse: I have the right not to sign this consent. If I refuse to sign this consent, McCullough Eyecare, PC has the right to refuse to treat me. However, treatment required by law –such as emergency care– can be provided to me whether or not I sign this consent.

Right to Review Notice of Privacy Practices: I have been provided with a copy of the Notice of Privacy Practices for McCullough Eyecare, PC which describes how McCullough Eyecare, PC may use and disclose my health information. I have the right to review this Notice before signing this consent.

Changes to the Notice of Privacy Practices: McCullough Eyecare, PC may change the Notice of Privacy Practices as needed. I may obtain a current copy of the Notice of Privacy Practices for McCullough Eyecare, PC by contacting McCullough Eyecare, PC via email.

Right to Request Restrictions on Use/Disclosure: I have the right to request that the usage of my protected health information by McCullough Eyecare, PC be restricted in how it is used and/or disclosed for the purpose of providing treatment, obtaining payment, and/or conducting health care operations.

Right to Withdraw Consent: I have the right to withdraw this consent at any time. I must do so in writing by contacting McCullough Eyecare, PC at 202 Walnut Street. Festus, MO 63028. My withdrawal of this consent will not be effective for uses and/or disclosures that have already been made based on my prior consent. If I withdraw this consent, then McCullough Eyecare, PC may refuse to provide to me further treatment or follow-up, other than required emergency services.

Effective Period: This consent is good unless and until I withdraw it in writing.

References to "I" or "me": References to "I" or "me" in this Consent include the individual for whom the signing party is authorized to sign. If I am signing this consent on behalf of another person, it is because I am that person's parent, legal guardian, or agent under an active Power of Attorney for Health Care; and I am legally authorized to sign this Consent on behalf of that person.

_____ _____
Signature of patient or authorized representative Date

_____
Print name of patient or authorized representative

FOR OFFICE USE ONLY

Complete this section if this form is not signed and dated by the patient or an authorized representative for the patient.
I have made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices for McCullough Eyecare, PC but was unable to for the following reason:

_ Patient refused to sign
_ Patient is unable to sign
_ Other _____

_____ _____
Signature of employee Date

_____
Employee's name