Gregory McCormick, MD • Cataract, Cornea & Refractive Surgery
Katherine Lane, MD • Cosmetic, Oculofacial Plastic & Reconstructive Surgery
David Shiple, MD • Cataract, Cornea & Comprehensive Ophthalmology
Pete Spitellie, MD • Eye Physician & Surgeon

AUTHORIZATION FORM

Consent under Vermont Law for Purposes of Treatment and Healthcare Operations. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

By signing this form, you consent to our use and disclosure of Protected Health Information about you for non-subsidized treatment, payment and health care operations, and for other purposes as permitted or required by law. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. Ophthalmic Consultants of Vermont provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

My Protected Health Information means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

You have the right to request that we restrict how Protected Health Information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, except in certain limited instances, but if we do, we shall honor that agreement.

X_____
Signature of Patient/ Guardian/ Personal Representative Date

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have been shown a copy of the Notice of Privacy Practices from Ophthalmic Consultants of Vermont.

X_____
Signature of Patient/Guardian/Personal Representative Date