EYE PHYSICIANS AND SURGEONS
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PATIENT CONSENT FORM

P.A. Terraciano, MD., PC, provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a Patients' Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. If we change our notice you may obtain a revised copy by contacting our office. 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.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. 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 on your prior consent. The patient understands:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations.
- P.A. Terraciano, MD., PC, have a Notice of Privacy Practices that you have the opportunity to review.
- The patient may revoke this consent in writing at any time and all future disclosures will cease.
- P.A. Terraciano, MD., PC, may condition treatment upon the signing of this consent.

Signature of Patient or Representative Date

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to P.A. Terraciano, MD., PC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Patient or Representative Date