Receipt of Notice of Privacy Policies and Consent Form

Drs. Gundersen and Zuker
www.gzeyecare.com

442 W. Western Ave.	1030 S. Mears Ave.	24 S. Michigan Ave.
Muskegon, MI 49440	Whitehall, MI 49461	Shelby, MI 49455
(231)722-3556	(231)893-5671	(231)861-5417
Fax (231)726-6334	Fax (231)893-7585	Fax (231)861-6655

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The ***Notice of Privacy Practices*** you have access to describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our ***Notice of Privacy Practices***, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our ***Notice of Privacy Practices***. Our ***Notice of Privacy Practices*** will be updated whenever our privacy practices change. You can get an updated copy here at the office or from our website.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform health care operations, As described in our ***Notice of Privacy Practices***, you have the right to request a restriction to your personal health information, however, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our Notice of Privacy Practices describes how to ask for a restriction.

EMERGENCY CONTACT:

Name______________________________________ Relationship__________________________ Phone___________________________

Permitted Use of Protected Health Information (in addition to EMERGENCY CONTACT above):

Please list family members or friends to whom we may disclose your personal health information in regard to health care and billing. For parents or legal guardians, please include any adults who may bring the patient to us in your absence.

Name _____________________________________ Relationship ____________________________ Phone __________________________

Name _____________________________________ Relationship ____________________________ Phone __________________________

Name _____________________________________ Relationship ____________________________ Phone __________________________

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations, I acknowledge that I have received the *Notice of Privacy Practices* for the office of Drs. Gundersen and Zuker. I agree to all of the above uses disclosures and understand that this will remain in effect until I notify Dr. Gundersen and Zuker of any changes.

Signature ____ Date ____

**If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form.

Name ___________________________________ Relationship to Patient _________________________ Source of Authority _______________