Receipt of Notice of Privacy Policies & Consent Form

Dr. William S. Diamond
6500 Dublin Blvd. Ste F, Dublin CA 94568
Phone Number: 925-828-7730
Fax Number: 925-828-2531

Patient Name: _____

Patient Date of Birth:_____ Patient Phone Number:_____

Patient Address: _____

In the course of providing service to you, we create, receive and store health information that indentifies 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 been given describes theses 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 if of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as 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 insures 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 ***Notices of Privacy Practices***. Our ***Notice of Privacy Practices*** will be updated whenever our privacy policy 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 pay for our services, and to perform healthcare operations. You also signify that you have received a copy of our ***Notice of Privacy Practices***.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our ***Notice of Privacy Practices***, 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.

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* from the office of Dr. William Diamond, O.D.

_____ _____
Signature Date

If signing as a personal representative of the patient, describe the relation to the patient and the source of authority to sign this form:

_____ _____
Relationship to Patient Print Name

Sources of Authority: _____