Student Health Services Eye Clinic
5500 Campanile Drive
San Diego, CA 92182-4701
TEL: 619-594-7360
FAX: 619-594-1911
http://shs.sdsu.edu

SDSU Eye Clinic
Consent for Use and Disclosure of Health Information

SECTION I: PATIENT/GUARDIAN GIVING CONSENT

Name: ______________________________ Date: ____________________

Address: ______________________________ State/Zip: ____________________

City: ______________________________ Red ID# ____________________

SECTION II: TO THE PATIENT/GUARDIAN -- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY:

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out our treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our *Notice of Privacy Practices* before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected heath information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

As a condition of your treatment by this office, financial arrangements must be made in advance. For predetermined treatment, the extent of the treatment will determine the acceptable financial arrangements offered. The patient is ultimately responsible for any and all costs incurred.

I hereby grant assignment of benefit rights to be paid directly to the provider of services.

I hereby authorize the San Diego State Student Health Services Billing Department to speak directly with my parent/guardian or policy holder. I understand this may entail the disclosure of my billing and/or clinical information to be used for the sole purpose of processing my insurance claim.

We reserve the right to change our privacy practices as described in our *Notice of Privacy Practices*. If we change our privacy practices, we will issue a revised *Notice of Privacy Practices*, which will contain the changes. Those changes may apply to your protected health information that we maintain.

You may obtain a copy of our *Notice of Privacy Practices*, including any revision of our Notice, at any time by contacting:

SDSU Eye Clinic: Student Health Services 5500 Campanile Drive San Diego, CA 92182 (619) 594-7360

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation to the contact listed above. Please understand that revocation of the Consent will not affect any action we took in reliance upon the Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. PLEASE ADVISE US IF YOU WOULD LIKE A COPY.

I ____________________ have acknowledged the *Notice of Privacy Practices* of this office and agree to them.
(Patient Name)

______________________________ ____________________
(Signature of Patient/Guardian) (Date)