Printed Name:_____

KENNEDY
VISION HEALTH CENTER

Responsibility for Payment and Release of My Information:

Your privacy is important. If you don't understand this form, please ask questions. We can make our Notice of Privacy Practices available to you. There are copies located at the front desk. We cannot accept changes to this form.

My consent to sharing (release) of my information:

- **For Treatment:** I authorize you, as my provider, to share my information with other healthcare professionals and facilities for treatment purposes, such as managing or coordinating my care, and related services.
- **For Payment:** I authorize you, as my provider, to share my information with my health plan and others as needed for payment purposes, such as eligibility and coverage determination, billing processing claims, coordinating benefits, utilization review, and related functions, including those functions that you, as my provider, are required by my health plan or other third-party payors to perform.

My responsibility for payment and assignment of benefits:

- I authorize you, as my provider, to bill my health plans (including Medicare/Medicaid and other third-party payers), directly on my behalf, so that you will receive direct payment of authorized benefits.

- I agree that it is my responsibility to pay for any items or services not covered by my health plans, such as co-payments, deductibles, or co-insurance.

My signature and acknowledgment:

My consent will be valid for ten years from the date I give it. I may revoke my consent to share my information, in writing, at any time. Revoking my consent doesn't apply to information that has already been shared. I understand that some uses and sharing of my information are authorized by law and do not require my consent.

For the purposes of my consent, "provider" means Kennedy Vision Health Center, and "my information" means information that identifies me and relates to my health and services received, as explained in more detail in the Notice of Privacy Practices.

My provider's Notice of Privacy Practices has been made available to me. It describes my privacy rights and additional disclosures my provider may make according to law.

I understand that Kennedy Vision Health Center provides me with a patient portal that provides me access to all my exam information including glasses and contact lens prescriptions that are downloadable and printable.

Signature _____ Date: _____ / ____ /_____