Universal Eye Center, PA
Medical, Surgical and Routine Eye Care
310 S. Main St., Rolesville, NC 27571
Phone: (919) 438-3937 Fax: (919) 435-6792

Patient Consent for use and Disclosure of Protected Health Information

I hereby give my consent for Universal Eye Center, PA to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

I have the right to review the Notice of Privacy Practices prior to signing this consent. Universal Eye Center, PA reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by request.

With this consent, Universal Eye Center, PA may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Universal Eye Center, PA may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked personal and confidential.

With this consent, Universal Eye Center, PA may email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request that Universal Eye Center, PA restrict how it uses or discloses my PHI to carry our TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Universal Eye Center, PA's use and disclosure of my PH to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Universal Eye Center, PA may decline to provide treatment to me.

*A copy of Universal Eye Center's privacy notice is posted and available should I want to review it. I may also request a copy of this form to keep for my personal records at any time.

Signature of Patient or Legal Guardian_____

Patient Name (please print)_____

Date_____