Orchard Eye Clinic

1111 E Cambridge St
Bolivar, MO 65613
Phone: (417) 567-0288
Fax: (417) 567-0244

Effective Date: January 1, 2025

NOTICE OF PRIVACY PRACTICES

Patient's Full Name: _____

Date of Birth: _____ **Social Security Number:** _____

PATIENT CONSENT FOR PHYSICIAN TO USE OR DISCLOSE HEALTH CARE INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE.

I UNDERSTAND THAT MY HEALTH INFORMATION IS PRIVATE AND CONFIDENTIAL. I UNDERSTAND THAT DR. SECHLER WORKS VERY HARD TO PROTECT MY PRIVACY AND PRESERVE THE CONFIDENTIALITY OF MY PERSONAL HEALTH INFORMATION.

I UNDERSTAND THAT SIGNING THIS DOCUMENT MEANS THAT DR. SECHLER MAY USE AND DISCLOSE MY PERSONAL HEALTH INFORMATION TO HELP PROVIDE HEALTH CARE TO ME, HANDLE BILLING AND PAYMENT, AND TAKE CARE OF OTHER HEALTH CARE OPERATIONS. FAILURE TO SIGN THIS CONSENT MAY RESULT IN THE PHYSICIAN DECLINING TO TREAT ME.

UNDER THE TERMS OF THIS CONSENT, I CAN ASK DR. SECHLER TO RESTRICT HOW MY PERSONAL HEALTH INFORMATION IS USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS. I UNDERSTAND THAT DR. SECHLER DOES NOT HAVE TO AGREE TO MY REQUEST. IF HE DOES AGREE TO MY REQUEST, I UNDERSTAND THAT HE WOULD FOLLOW THE AGREED LIMITS.

I UNDERSTAND THAT I HAVE THE RIGHT TO CANCEL THIS CONSENT IN WRITING AT ANY TIME. IF I DO CANCEL THE CONSENT, I UNDERSTAND THAT DR. SECHLER MAY HAVE ALREADY USED OR DISCLOSED INFORMATION ABOUT ME, AND CANCELING THIS CONSENT WOULD NOT AFFECT THE INFORMATION ALREADY USED OR DISCLOSED.

I MAY CANCEL THIS CONSENT AT ANY TIME BY DOING THE FOLLOWING:

WRITING, SIGNING, AND DATING A LETTER TO DR. SECHLER THAT SAYS I WANT TO REVOKE MY CONSENT TO AUTHORIZE THE USE AND DISCLOSURE OF MY PERSONAL HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPTIONS.

I UNDERSTAND IF I CANCEL THIS CONSENT, DR. SECHLER IS NOT OBLIGATED TO PROVIDE FURTHER HEALTH CARE SERVICES TO ME.

TO GIVE CONSENT TO DISCLOSE HEALTH CARE INFORMATION TO SOMEONE OTHER THAN THE PATIENT, PLEASE WRITE THEIR NAME BELOW: (E.G. FAMILY MEMBER, CARETAKER)

Name: _____

MY SIGNATURE BELOW INDICATES THAT I AGREE TO THE POLICIES OUTLINED BY THIS DOCUMENT AND ALL STATEMENTS THEREIN.

Patient Signature: _____ **Date:** _____

IF SIGNED BY ANYONE OTHER THAN HIM/HER (PARENT, LEGAL GUARDIAN, PERSONAL REPRESENTATIVE, ETC.)

Authorized Signature: _____ **Date:** _____