Chris J. Gualtieri, MD, APC
Eye Laser and Vision Center, *A Professional Corporation*
&
Corique Optical
3969 Fourth Avenue #301
San Diego, CA 92103
619-688-2648

HIPAA Consent for the Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my **protected health information** by Dr. Chris Gualtieri, his staff, or Corique Optical (the "office") for the purpose of providing treatment to me, obtaining payment for my health care, or to conduct health care related business operations at this office.

My **protected health information** means information including my demographic information collected from me, created or received by Dr. Gualtieri, another health care provider, a health plan, my employer or a health care clearing house. The protected health information related to my past, present or future physical or mental health or that identifies me or there is a reasonable basis to believe the this information may identify me.

The diagnosis and treatment of my health conditions by Dr. Gualtieri may be affected by this consent. I have the right to request a restriction as to how my protected health information is used or disclose to carry out treatment, payment or health care related operations of this office. This office is not required to agree to the restrictions that I may request. However, if this office agrees to a restriction that I request, the restriction is binding on this office and Dr. Gualtieri's care.

Please restrict release of the following information:_____

To the following entity_____

I have a right to change or revoke this consent at any time in writing except to the extent that Dr. Gualtieri, his staff, or Corique Optical have already taken action in reliance on this consent.

I have a right to review this office's complete "NOTICE OF PRIVACY PRACTICES" prior to signing this document. A copy of the NOTICE OF PRIVACY PRACTICES for this office is available on request. The NOTICE OF PRIVACY PRACTICES describes in detail my rights and the office's duties with respect to my health information.

This office reserves the right to change the content of the privacy practices at any time. I may obtain a revised copy by contacting the privacy officer and the revised copy will be sent by US Mail or delivered to me in person at my next appointment.

Signatures of patient _____ Date _____

Signature of patient's representative _____ Date _____

Representative's relationship to the patient _____

The HIPPA privacy officer is Roberta Reeves. She can be reached at 619-688-2648