Retina Associates of St. Louis

PRIVACY POLICY OUTLINE AND COMMUNICATION CONSENT

We collect personal health information about you directly from you and this personal health information may include, for example, your name, date of birth, address, e-mail address, phone numbers, health history and records of your visits.

This information is used for:

- Diagnosis and treatment
- Billing your insurance company directly or through a third party in order to receive payment for services rendered
- Compliance with legal and regulatory requirements and to fulfill other purposes permitted by law
- Conducting quality improvement activities such as sending patient satisfaction surveys, informational letters and coupon advertising

We take steps to protect your personal health information from theft, loss and unauthorized access, copying, modification, use, disclosure and disposal.

- We conduct audits and complete investigations to monitor and manage our privacy compliance.
- We take steps to ensure that everyone who performs services for us protects your privacy and only uses your personal health information for the purposes you have consented to.

For more information about our privacy protection practices, or to raise a concern you have with our practice, contact us at:

Retina Associates of St. Louis, Inc.
1224 Graham Rd. Suite 3011
Florissant, MO 63031
Attention: Sherrie Kleekamp, Privacy Officer

PATIENT COMMUNICATION INFORMATION

_____ _____

First and Last Name Email Address

_____

Address City State Zip

_____ _____

Home Number Mobile Number

_____ _____

Work Number Work Number Extension

Indicate who is authorized to receive your medical information, other than yourself.

_____

First and Last Name

_____

First and Last Name

_____

First and Last Name

May we contact you by mail? ❑ Yes ❑ No

May we leave a message on your answering machine? ❑ Yes ❑ No

If YES please provide phone number _____

May we leave a message with another person if you are unavailable? ❑ Yes ❑ No

May we fax information to you? ❑ Yes ❑ No

If YES please provide fax number _____

May we send information to you via e-mail? ❑ Yes ❑ No

If YES please provide email address _____

I _____ (First and Last Name) have reviewed Retina Associates of St. Louis, Inc's (RASL) Privacy Policy concerning the collection, use and disclosure of personal health information.

I understand that RASL is seeking my consent to collect, use and/or disclose my personal health information from me or from the person acting on my behalf for any or all of the purposes listed above.

I understand that I can refuse to sign this consent form and that I can withdraw my consent at any time by writing to RASL. I understand that refusal to sign this consent form or withdrawal of my consent may result in Retina Associates of St. Louis refusing to provide services to me.

I hereby authorize Retina Associates of St. Louis, Inc. to collect, use and disclose my personal health information for the purposes listed above.

_____ _____

Patient Signature Date