Retina Center of Maine
Mark W. Balles, MD
195 Fore River Parkway, Suite 480
Portland, Maine 04102
Phone: 207-773-3938 Fax: 207-773-0801
www.retinamaine.com

Patient ID #: _____

Consent to Use and Disclosure of Protected Health Information

I consent to Retina Center of Maine use and disclosure of my protected health information (PHI) in support of my diagnosis and treatment, payment for the medical services I receive, and the legitimate health care operations of the medical practice.

I consent to Retina Center of Maine disclosure of PHI to other health care practitioners and facilities that are involved in providing medical services to me and to my family and close friends who are providing me with emotional support as I receive medical services. Also, I consent to The Retina Center of Maine disclosure of PHI to my health insurance carrier, utilization review organization, or third-party administrator to support payment for my medical services.

I understand that Retina Center of Maine's agreement to provide medical services to me is conditioned upon my signing of this consent and that Retina Center of Maine requests my consent to ensure that Dr. Balles can properly carry out the professional responsibility of caring for me.

I understand Retina Center of Maine will disclose only the minimum amount of my health care information which is necessary, in the judgment of Retina Center, for the legitimate needs of the recipient or for my general well -being.

My PHI, which is subject of this consent, includes demographic information; information about my physical or mental health or condition; information about medical services provided to me, including payment information, if any of that information may be used to identify me.

I understand that I have a right to restrict Retina Center of Maine's use and disclosure of my PHI and that Retina Center is not obligated to agree to the requested restriction, but that an agreement to a restriction binds Retina Center of Maine. I may revoke this consent at any time by providing Retina Center of Maine with a written, signed, and dated request except to the extent that Retina Center of Maine has acted in reliance upon my consent. However, I understand that any restriction on the use and disclosure of PHI or revocation of this consent may result in improper diagnosis or treatment, denial of coverage of a claim for insurance benefits, or other adverse consequences.

I acknowledge that this consent will remain in effect for all subsequent uses and disclosures for the limited purposes outlined about for 30 months from the date of this consent unless I revoke it earlier as described above.

I understand that Retina Center of Maine regards the safeguarding of PHI as an important duty. I understand, furthermore, that the elements of this consent are required by state and federal law for my protection and to ensure my informed consent to the use and disclosure of PHI necessary to support my relationship with Retina Center of Maine.

I have received a copy of Retina Center of Maine's Notice of Privacy Practices that provides a more complete description of the uses and disclosures addressed above and I have had an opportunity to review the Notice of Privacy Practices before signing this consent. I acknowledge that Retina Center reserves the right to amend the Notice of Privacy Practices periodically; I understand that I may obtain a current copy of the Notice by contacting the office staff at any time.