Current Medications List

Patient Name: _____Date _____

Systemic Medications:

Name of Medication	Strength/ Frequency	Condition Medication Taken For	Notes

Eye Medications:

Name of Medication	Strength/ Frequency	Condition Medication Taken For	Notes Eye Left/Right/Both

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by the practice for the purpose of diagnosing or providing treatment to me, obtaining payment for my heath care bill or to conduct heath care operations. I understand that all diagnosis or treatment of me by the practice may be conditioned upon my consent as evidenced by my signature of this document.

I understand I have the right to request a restriction as how my protected health information is used or disclosed to carry out treatment, payment or health care operations of this practice. The practice is not required to agree to the restrictions that I may request. However, if the practice agrees to a restriction I request, the restriction is binding on the practice.

I have the right to revoke this consent, in writing, at any time, except to the extent that the practice has taken action in reliance on this consent.

My protected health information means health information, including demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me or this is a responsible basis to believe the information may identify me.

I understand that I have a right to review the practice's Notice of Privacy Practices prior to signing this document.

_____ _____

Signature of Patient or Parent/Guardian if under 18 Date

Reviewed with Patient (Date/Initials)