E-Prescribe Consent Information

I consent for Drs. Weinberger & Vizy, LLC to obtain my medication prescription history and place my prescription orders through the electronic prescribing system.

1. **Pharmacy Name:** _____
   Pharmacy Number: _____
   Pharmacy Zip Code: _____

2. **Pharmacy Name:** _____
   Pharmacy Number: _____
   Pharmacy Zip Code: _____

INITIAL: _____

HIPPA Consent Form

I consent to the use or disclosure of my protected health information by Drs.Weinberger & Vizy L.L.C for the purpose of diagnosing and/or providing medical treatment to me, obtaining payment for my health care bills or to conduct the health care operations of Drs. Weinberger & Vizy I understand that diagnosis and/or treatment of me by Drs. Weinberger & Vizy may be conditioned upon my consent as evidence by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Drs. Weinberger & Vizy is not required to agree to the restrictions that I may request, and may refuse treatment based on my restrictions as permitted by Section 164.506 of the Code of Federal Regulations.
However, if Drs. Weinberger & Vizy agrees to a restriction that I request, the restriction is binding on Drs. Weinberger & Vizy L.L.C.

I have the right to revoke this consent, in writing, at any time, except to the extent that Drs. Weinberger & Vizy or Dr. Weinberger has taken action in reliance on this consent. (Revocation begins upon the date written notice is received).

My "protected health information" means health information, including demographic information, collected from me and created for or received by my physician, another healthcare provider, a health plan, my employer, healthcare financial recovery service or healthcare clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Drs. Weinberger & Vizy's Notice of Privacy Practices prior to signing this document.
Drs. Weinberger & Vizy's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of Drs.Weinberger & VizyL.L.C The Notice of Privacy Practices for Drs. Weinberger & Vizy is also provided – posted in waiting room at 3690 Orange Place Suite # 230 Beachwood, Ohio. This Notice of Privacy Practices also describes my rights and Drs. Weinberger & Vizy's duties with respect to my protected health information.
Drs. Weinberger & Vizy reserves the right to change the privacy practices that are described in the Notice of Privacy Practices in accordance with Section 164.520 of the Code of Federal Regulations . I may obtain a revised notice by calling the office at _____ and requesting a revised copy be sent in the mail or by asking for a copy at the time of my next appointment.

- Consent Restrictions Requested: _____

_____

_____

I _____accept _____reject the terms of this consent

X_____
Signature of Patient or Personal Representative

_____
Description of Personal Representative (Relationship)

_____
Printed Name of Patient

_____
Date

I authorize Drs. Weinberger & Vizy L.L.C to leave messages on my answering machine (pertaining to healthcare) with my spouse or designated family member. _____ YES _____ NO

_____

X_____