



PT. # _____

Patient Privacy Consent

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. California Eye Professionals provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- California Eye Professionals has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- California Eye Professionals reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but California Eye Professionals does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- By signing below I acknowledge receipt of the "Summary of Privacy Practices" dated Sept 23, 2013.

I authorize telephone communication and disclosure of protected health information with the following: _____

Signature: _____
Signature - Patient or Representative

This Consent was signed by: _____
Printed Name – Patient or Representative

Relationship to Patient (if other than patient): _____

Date: ____ / ____ / ____

In front of: _____
Printed Name – Practice Representative