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Diseases of the Retina, Vitreous, and Macula

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

PURPOSE OF CONSENT: By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and health operations.

NOTICE OF PRIVACY PRACTICES: Enclosed is a copy of our Notice of Privacy Practices. You may keep the Notice for your records, or you may return it to the front desk. This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

We reserve the right to change our privacy practice as described in our Notice of Privacy Practices. If we change our privacy practice, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

RIGHT TO REVOKE: You have the right to revoke this consent at any time by giving us written notice of your revocation. Please understand that the revocation of this consent will not affect any action we took before your revocation, and that we may decline to treat you or continue treating you if you revoke this consent.

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I have had full opportunity to read and consider the form. I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations. You are entitled to a copy of this consent after you sign it.

Patient's Name: _____ Date of Birth: _____

MAY WE ADDRESS YOU BY NAME IN THE WAITING ROOM?
YES ☐ NO ☐

Patient or Representative's Signature: _____

Date: _____ If signed by representative, indicate relationship: _____