Patient Name:______________________________
Date of Birth:______________________________
Medical Record Number:______________________

Consent to Use/Disclose Protected Health Information

Your medical information may be used and disclosed to carry out your treatment, bill and receive payment and for health care operations. More specific information pertaining to our practice policies is provided for you in our "Notice of Privacy Practices" statement. You have a right to review this statement prior to receiving health care and prior to signing this consent.

The terms of our "Notice of Privacy Practices" may change at any time. You may contact the office and request a revised policy. Also, if you so choose, you may request that we restrict the use of your health information for the purposes of treatment, payment, and/or health care operations. Our physicians are not required to agree with the restriction. If the physicians believe it is in your best interest to permit use and disclosure of your protected health information, this information will not be restricted.

I understand that I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent

I acknowledge that I have received a copy of the "Notice of Privacy Practices" from Center for Sight, and I consent to the above noted terms related to the use and disclosure of my individually identifiable health information for the purposes of treatment, payment and/or health care operations.

______________________________	______________________________
Patient name (printed)	Date
______________________________	______________________________
Patient, parent or legal guardian signature	Relationship to patient of the person signing

If written acknowledgement is not obtained, please check the reason:

☐ Notice of Privacy Practices given – patient unable to sign

☐ Notice of Privacy Practices given – patient declined to sign

Reason patient declined to sign:____

• •

______________________________	______________________________
Employee witness	Date