



SPECIALIZED EYE CARE

PATIENT CONSENT FORM

Specialized Eye Care's ("SPEC") 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. **YOUR HAVE A 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.

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 a right to revoke this Consent in writing and signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance of your prior Consent. SPEC provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

You understand that:

- Protected health information may be disclosed for treatment, payment or health care operations.
- SPEC has a Notice of Privacy Practices and that you have the opportunity to receive a copy of such Notice.
- SPEC reserves the right to change the Notice of Privacy Practices.
- You have a right to restrict the use of your information but SPEC does not have to agree to those restrictions.
- You may revoke this Consent, in writing, at any time and all future disclosures will then cease.
- SPEC may not condition treatment upon the execution of this Consent.

Patient Name _____ Account No. _____

Signature of Patient or Representative Date

Printed Name of Patient or Representative If Representative, Relationship to Patient

If you would like us to share your private health information with anyone, please list the name(s) of the person(s) and their relationship to you.

Name Relationship to Patient

Name Relationship to Patient