COASTAL EYE CARE

Acknowledgement of receipt of Notice of Privacy Practices Consent for Use and Disclosure of Health Information and Release form

As of April 14, 2003, all Healthcare Providers are required to post this notice and to make a good faith effort to obtain signed Consent from their patients. This Consent form is legally necessary for us to assist you with, but not limited to, tasks such as insurance pre-approval and filing, medical consultations if necessary, laboratory coordination and even appointment reminders.

I, _____ have read, reviewed and considered the contents of this Consent form and was given (or offered) a copy of and read your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your disclosure and use of my protected health information in any form deemed necessary in conjunction with common practices and professional judgment.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Print Name of Patient

Your Right to Revoke Consent

You have the right to revoke this Consent by giving us written notice of your revocation. We retain the right to decline to treat you or to continue treatment should you choose not to sign this Consent or choose to revoke it at a later time. You are entitled to a copy of this Consent after it is signed. We support your right to the privacy of your health information. If you have any further questions about our Health Information Privacy Policies and Procedures, please inquire at the reception desk.

Request of Exemption: If you selected this option, please write your exemption request below.

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