PATIENT CONSENT and AUTHORIZATION
For Use and Disclosure of Health Information

Patient Name: _____ **DOB:**_____

The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I understand and consent that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a *Notice of Privacy Practices* and the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will cease.
- The Practice may condition treatment upon the execution of this Consent.

You may authorize certain individuals to receive or disclose your private health information as follows:.

I give my consent for Retina Associates SW to provide health information about me to:

Myself: _____ _____ _____
Home phone Cell phone Work phone

Spouse: Name_____ Phone #_____

Child: Name_____ Phone #_____

Parent: Name_____ Phone #_____

Name_____ Phone #_____

Other: Name_____ Phone #_____

List information you *would not like released* and to whom:

_____

_____

By signing this form, you authorize Retina Associates SW to use and disclose protected health information about you as outlined above. You have the right to revoke this authorization at any time, in writing, signed by you. Such revocation shall not affect any disclosures we have already made in reliance on your prior authorization.

X_____
Patient Signature Date

RETINA ASSOCIATES SOUTHWEST PC

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