

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and health care operations.

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation. Please understand the revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Patient Name

Date

Patient Signature

Date

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGMENT

I, _____, have reviewed/received
Patient Name

a copy of the Notice of Privacy Practices of Eye Consultants of Bonita Springs.

Signature of Patient/Guardian

Date

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date:	Intials:	Reason:
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