Authorization for Use or Disclosure of Health Information

Our Notice of Privacy provides information about how Capital Eye Consultants may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that, by your signature, you have reviewed our notice before signing this consent.

Per HIPAA regulations (Health Insurance Portability and Accountability Act of 1996), you are afforded the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

May we phone, email, or text you to confirm appointments? Yes No
May we leave a message on your answering machine at home or on your cell phone? Yes No
May we discuss your medical condition with any member of your family? Yes No

If YES, please name the members allowed to receive/discuss information about your medical condition:

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Name of Patient (Please print)

____________________________________ ____________________
Signature of Patient Date

____________________________________ ____________________________________
Signature of Patient Representative Relationship of Patient Representative to Patient

(Required if the patient is a minor or an adult who is unable to sign this form)