



1055 37th Place | Vero Beach, FL 32960

T: 772.257.8700 | F: 772.257.8705

NewVisionEyeCenter.com | f @ t

PATIENT CONSENT FORM FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this Consent Form, you give us permission to use and disclose protected health information about you for treatment, payment, and healthcare operations except for any restrictions specified below to which we have agreed. Protected health information is individually identifiable information we create or receive, including demographic information, relating to your physical or mental health, to provision of healthcare services to you, and to the collection of payment for providing healthcare services to you.

Our Notice of Privacy Policy provides information about how we may use and disclose protected health information about you. As provided in our Notice, the terms of the Notice of Privacy Policies may change. If we change our Notice, you may obtain a revised copy by contacting our information privacy official, Administrator James Hughes at 772-257-8700, who is also available to respond to any questions or receive any complaints you may have concerning your protected health information.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or healthcare operations. We are not required to agree to any restrictions, but if we do, we are bound to our agreement. If you wish to make a restriction, please request a copy of our Form to Request Restrictions.

If you do not sign this Consent Form, we have the right to refuse your treatment unless a licensed healthcare professional has determined that you require emergency treatment or we are required by law to treat you. We are required to document any circumstances in which we do not obtain your consent, yet carry out treatment. We will offer you a copy of this documentation should you decide not to sign this Consent Form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. You may request to use our Authorization for Release of Information for purposes of requesting your revocation, or you may simply send us a letter in writing. By signing this consent, you acknowledge that you have received a copy of the "Notice of Privacy Policies."

Please list the names of additional people we may disclose your protected health information to, either by phone or documentation:

NAME: _____	RELATIONSHIP TO PATIENT: _____
NAME: _____	RELATIONSHIP TO PATIENT: _____
NAME: _____	RELATIONSHIP TO PATIENT: _____

Patient's Signature

Date