Patient Consent and Acknowledgement of Receipt of Privacy Practices

I understand that as part of the provision of healthcare services, ArkLaTex Eyes creates and maintains health records and other information describing among other things, my health history, which includes, but not limited to: chief complaint, symptoms, examination, test results, diagnoses, treatment and any plans for future care or treatment.

I have read and understand the "Notice of Privacy Practices" that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I also understand that ArkLaTex Eyes reserves the right to change their notice and practices. In this case, a copy of any revision could be posted in the office, posted on company web-site, and/or mailed to me. I understand that I have the right to object to the use of my healthcare information. I also understand that I have the right to restrict to how my healthcare information may be disclosed to carry out treatment, payment or other matters in regards to healthcare operations. I also understand that ArkLaTex Eyes is not required to agree to the restrictions requested.

ArkLaTex Eyes is authorized by this signed form to disclose or discuss my "Protected Health Information" with the following named individuals:

Name & Relationship

____ □ Medical Information □ Appt □ Product Pick-Up
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By signing this form, I consent to use and disclosure of my protected healthcare information for the purpose of treatments, payment and any other healthcare operations. I have the right to revoke this consent in writing, except where disclosures have already made a reliance on my prior consent.
This consent is freely given by and on this date:

Patients Printed Name: ____

Patient Signature/Guardian: ____Date:_____________________________

Address: ____

Last Four Digits of Social Security Number for ID Purposes: ____

Phone: ____ E-mail: ____

Employer: ____

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