SIDNEY
VISION CLINIC

A member of My Family Vision Clinic, LLC

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATIONS

SECTION A: PATIENT GIVING CONSENT

Name: _____ **DOB**:_____

Address: _____ **City, State, Zip**:_____

Phone: (H)_____**(W)**_____**(C)**_____

Occupation: _____
Name of Medical Doctor: _____
Pharmacy: _____

SECTION B: TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

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

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will obtain the changes. Those changes may apply to any of your protected health information that we maintain.

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 that revocation of the consent will NOT affect any action we took in reliance on the consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

Section C: Signature

I have had full opportunity to read and consider the contents of the consent form and Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry our treatment, payment activities and health care operations.

Signature: _____**Date**:_____

If this consent is signed by a person representative on behalf of the patient, complete the following:

Personal Representative's Name:_____

Relationship to Patient:_____