Flower Mound Eye Care Associates

Consent for use and Disclosure of Health Information

Section A: Patient Giving Consent

Section B: To the Patient- Please read the following statements carefully.
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 submission of insurance.

Notice to Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides description of our treatment, payment activities, and healthcare operations. There is a copy posted in our waiting area. Upon request, we can issue you a copy of this policy.

You may obtain a copy from our office or contact the following person at any time.

Tammy Hall
Flower Mound Eye Care Associates
3851 Long Prairie Rd. Suite 100
Flower Mound, TX 75028
(P) 972.724.3030
(F) 972.691.3721

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any prior action taken 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.

Signature:

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

_____ _____
Patient Signature Date

_____ _____
Personal Representative Name Relationship to Patient