PREMIER VISION CARE

OPTOMETRY

HIPAA PATIENT CONSENT FORM: INFORMATION ACCESS CONSENT

I understand that my medical records are confidential. My signature authorizes Premier Vision Care Optometry or any designate in this optometric practice to access and release my medical records for the purpose of providing care and treatment, or to fulfill requirements of any insurance I have. I understand I may revoke this authorization in writing at any time.

_____ _____

Print Name Date

_____

Patient Signature

PHOTOGRAPHY/ VIDEOGRAPHY CONSENT FORM (Optional)

I give permission to Premier Vision Care Optometry to use my Images/ Photographs or Videos in publications and advertisements produced by or for Premier Vision Care Optometry now or in the future.

I understand that the items above may:

- Appear on the Internet/ World Wide Web (WWW)
- Appear in print, electronic, or video media.

_____ _____

Print Name Date

_____

Patient Signature