HIPAA CONSENT FORM

I give Mountain View Eye Center my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations such as quality reviews.

I have been informed that I may review Mountain View Eye Center's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that Mountain View Eye Center has the right to change their privacy practices and that I may obtain any revised notices at Mountain View Eye Center.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that Mountain View Eye Center is not required to agree to the request. If Mountain View Eye Center agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Patient Name____

Signature____ Date_________________

If signed by patient representative, print name ____________________________________

State relationship to patient________________________