

**Flower Mound
Eyecare Associates
3851 Long Prairie Rd
Suite 100
Flower Mound, TX 75028
972.724.3030
Fax: 972.691.3721**

Consent for use & Disclosure of Health Information

Section A: Patient Giving Consent

Patient Name: _____ Patient Phone Number: _____

Patient Address: _____

Email: _____

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 anytime:

Contact Person: Tammy Hall
972.724.3030 Fax: 972.691.3721
Address: 3851 Long Prairie Rd Ste.100 Flower Mound, TX 75028

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.

Signature Date

Personal Representative's Name Relationship to Patient