PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION AND ACKNOWLEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, hereby give my consent to:
(*Name of Patient or Authorized Agent*) *Mack Eye Center* to use or disclose, for the purpose of carrying out treatment, payment or health care operations, all information contained in the patient record of _____.
(*Patient's Name*)

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that *Mack Eye Center* has reserved a right to change its privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available on request or at my next office visit.
I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where The physician has already relied on it to use or disclose my health information. Written Revocation of consent must be sent to the physician's office.
I also understand and agree that *Mack Eye Center* may contact me by phone or mail at the address and/or phone numbers I have provided and may leave voice messages, if necessary, in carrying out treatment, payment or health care operations on my behalf. I understand that I may request limitations on the method of contact by submitting a request in writing to: HIPAA Director at this office

_____ _____
Patient Signature Date