

Frisco Eye Associates
7638 Stonebrook Pkwy
Frisco, Texas 75034
(Phone) 972-712-1010 (Fax) 972-712-1011

Consent for Use & Disclosure for Health Information

Section A: Patient Giving Consent

Patient Name: _____ Patient Phone Number: _____

Patient Address: _____

E-mail: _____

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 only carry out treatment, payment activities and submissions of insurance.

Notice to Privacy Practices: You have the right to read your Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and health care 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 by contacting us at the following:

Telephone: 972.712.1010 **Fax:** 972.712.1011

E-mail: friscoeye@friscoeye.net

Address: 7638 Stonebrook Parkway, Frisco, Texas 75034

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 the 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 insurance filing, treatment, and payment activity.

Signature

Date

Personal Representative's Name

Relationship to Patient