DEL NEGRO & SENFT EYE ASSOCIATES

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under federal law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.
Del Negro & Senft Eye Associates provided this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- Del Negro & Senft Eye Associates has a Notice of Privacy Practices and that the patient has the opportunity to be informed of and receive and review a copy of this Notice.
- Del Negro & Senft Eye Associates reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information, but Del Negro & Senft Eye Associates does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- Del Negro & Senft Eye Associates may condition treatment upon the execution of this Consent.

The undersigned has read and understands the terms of this Consent and has had opportunities to ask questions about the use and disclosure of his/her protected health information. The undersigned hereby knowingly and voluntarily authorizes Del Negro & Senft Eye Associates to use or disclose his/her protected health information in the manner described above and in the Notice.

Signature:_____

This Consent was signed by :_____Date:_____
Printed name –Patient or representative

Relationship to Patient (if other than patient):_____

In front of_____(Practice representative)