Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in treatment directly and indirectly; obtain payment from third party payers; conduct normal healthcare operations such as quality assessment and physician certification.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such notices before signing this consent. I understand this organization has the right to change their Notices of Privacy Practices from time to time and that I may request a current copy at any time from the below address.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing anytime, except to the extent that you have taken, action relying on this consent.

By signing this form, I acknowledge receipt of the Notice of Privacy Practices of Westminster Vision Associates, which outlines how they may use and disclose my protected health information.

Patient name: ___________________________________

Signature: _____________________________________

Relationship to patient: ________________________________

Date: ________________________________