WESTMINSTER VISION ASSOCIATES

Patient Consent Form

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 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. This information will also 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 Westminster Vision of their Notice of Privacy Practices containing a more complete description of the uses and disclosers 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 and that I may request a current copy at any time.

I understand that I may request, in writing, that Westminster Vision restricts how my private information is used or disclosed to carry out treatment, payment and/or healthcare operations. I also understand that Westminster Vision is not required to agree to my requested restrictions, but if agreed upon are bound to abide by them.

I understand that I may revoke this consent in writing at any time, with the exception of the extent that has been already taken.

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

Patient Name (Print): _____

Patient/Legal Guardian Signature: _____

Date: _____