

**RUMMEL EYE CARE, PC**  
**PATIENT CONSENT FOR USE/DISCLOSURE OF**  
**PROTECTED HEALTH INFORMATION**

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
**SSN:** \_\_\_\_\_ **Other name(s) [maiden,etc.]:** \_\_\_\_\_

I understand that my health information is private and confidential. I understand that Rummel Eye Care, PC works hard to protect my privacy and preserve the confidentiality of my health information.

I understand that Rummel Eye Care, PC may use and disclose my health information to provide treatment to me, the patient, to handle billing and payment, and to take care of other healthcare operations.

I understand that Rummel Eye Care, PC has a detailed document called the "Notice of Privacy Practices". It contains more detailed information about how this office may use and disclose patient health information. I understand that I have a legal right to read the "Notice" before I sign this consent.

I understand that Rummel Eye Care, PC may update the "Notice of Privacy Practices" at any time. Upon request, Rummel Eye Care, PC will provide me with the most current copy of the "Notice".

I understand that under the terms of this consent, I can ask Rummel Eye Care, PC to restrict how my health information is used or disclosed to carry out treatment, payment, or healthcare operations. I understand that Rummel Eye Care, PC does not have to agree to my request, but if Rummel Eye Care, PC does agree to my request, I understand that Rummel Eye Care, PC will remain within the agreed limits.

I understand that I may cancel this consent in writing at any time by writing, signing, and dating a letter to Rummel Eye Care, PC. If I write a letter, it must say that I want to revoke my consent to authorize the use and disclosure of my health information for treatment, payment, and healthcare operations.

I understand that if I revoke this consent, Rummel Eye Care, PC does not have to provide any further healthcare services to me, the patient.

My signature below indicates that I have been given the chance to review a current copy of Rummel Eye Care, PC's "Notice of Privacy Practices". My signature means that I agree and consent to allow Rummel Eye Care, PC to use and disclose my protected health information to carry out treatment, payment, and healthcare operations.

\_\_\_\_\_  
**Signature of patient or patient's representative**      **Date**      **Time**

\_\_\_\_\_  
**Printed name of patient/patient's representative**      **Relationship to patient**