Atlantic Eye
CONSULTANTS

CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____, consent to the release of protected health information that is required to carry out treatment or payment of healthcare operations on my behalf.

I have read the Notice of Privacy Practices and am aware of the following:

- I have the right to place restrictions on the way my protected health information is used or disclosed.
- I understand that Atlantic Eye Consultants is not required to agree with my requested restrictions. I also understand that once Atlantic Eye Consultants agrees to my restrictions, it must comply with those restrictions.
- I have a right to revoke my consent for the use and disclosure of my protected health information at any time. I understand that, if I choose to revoke my consent, I must submit a signed written statement.
- I understand that Atlantic Eye Consultants must immediately comply with my request to revoke consent, except to the extent that it has already taken some action that was based on my original consent.
- Atlantic Eye Consultants has reserved the right to change from time to time our privacy policies that are described in the Notice of Privacy Practices. Whenever we change our practices, we will modify the notice accordingly inform you on your next visit.

Individual:	Parent/Legal Guardian or Witness:
_____	_____
Printed Name	Printed Name
_____	_____
Patient Signature	Signature
_____	_____
Date	Date