HIPAA NOTICE OF PRIVACY PRACTICES

Patient Consent Form

I acknowledge that I was offered or provided with a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) & understood the notice.

The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use and disclosure of Protected Health Information (PHI) for treatment, payment, and healthcare operations.

By signing this form, you consent to our use and disclosure of your PHI. I understand that this consent is voluntary and **will expire 3 years from date of signature**, however it may be revoked at any time by notifying Aldridge Eye Institute in writing.

_____

Patient Name (Print)

_____

Parent/Authorized Representative (if applicable)

Authorization for Release of Information

I hereby authorize Aldridge Eye Institution to disclose my individual medical information to the person(s) listed below. I understand that this consent is voluntary and **will expire 3 years from date of signature**, however it may be revoked at any time by notifying Aldridge Eye Institute in writing.

Person(s) allowed to receive my medical information Relationship to patient

_____

_____

Signature_____Date_____

Revised 02/2022