

Pro-Optix Eye Care
5885 San Felipe Suite 550
Houston Texas 77057
Phone: (713-360-7095)

Our notice of privacy practices provides information about how we may use and disclose protected health information. The notice contains a patient rights section describing your rights under the law you have the right to review our notice before signing this consent. The terms of our notice may change if we change our notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how we protect health information about you, how it is used, and or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do we shall honor that agreement.

By signing this form, you consent to our use and disclosure to protect health information about your treatment, payment and health care operations. You have the right to revoke this consent, in writing signed by you. However, such a revocation shall not affect any disclosure we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The practice has a Notice of Privacy Practices and that the patient has had the opportunity to review the notice.
- The practice reserves the right to change the Notice of Private Policies.
- The patient has the right to restrict the uses of their information but the practice does not have to agree to those restrictions.
- The patient may revoke this consent at any time and all future disclosures will then cease.
- The practice may condition treatment upon execution of this consent.

Signature and Date: x_____ Date: _____

Due to HIPAA, the following information must be updated by each patient annually.

I authorize Pro-Optix Eye Care to release my medical or insurance information as necessary to process my medical claims and coordinate or manage my health care.

Signature and Date: x_____ Date: _____