Patient Consent Form

For Use/Disclosure of Health Care Information

Retina and Vitreous of San Antonio PLLC has a detailed document called "Notice of Privacy Practices". The Notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed and understood our notice before signing this consent.

The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement.

In general, there will be no other uses and disclosures of your protected health information unless you permit it. However, sometimes the law may require the release of this information without your permission. These situations are unusual. One example would be if a patient threatened to hurt someone.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The patient has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____