VISION SOURCE®

Patient Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, Vision Source of Texarkana creates and maintains health records and other information describing among other things, my health history, which includes, but not limited to: chief complaint, symptoms, examination, test results, diagnoses, treatment and any plans for future care or treatment.

I have been provided with the "Notice of Privacy Practices" that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I also understand that Vision Source of Texarkana reserves the right to change their notice and practices. In this case, a copy of any revision could be posted in the office, posted on company web-site, and/or mailed to me. I understand that I have the right to object to the use of my healthcare information. I also understand that I have the right to restrict to how my healthcare information may be disclosed to carry out treatment, payment or other matters in regards to healthcare operations. I also understand that Vision Source of Texarkana is not required to agree to the restrictions requested.

By signing this form, I consent to use and disclosure of my protected healthcare information for the purpose of treatments, payment and any other healthcare operations. I have the right to revoke this consent in writing, except where disclosures have already made a reliance on my prior consent.

This consent is freely given by and on this date:

Patients Printed Name:_____

Patient Signature/Guardian:_____Date:_____

Last Four Digits of Social Security Number for ID Purposes:_____

Office Use Only: □ Completed by:_____Date:_____