SouthEast Eye Physicians & Surgeons

CONSENT FOR USE AND DISCLOSURE OF CONFIDENTIAL HEALTH INFORMATION

PATIENT'S NAME: _____

By signing this form, you are consenting to (Raffi Karapetian, D.O., V. Stephen Slana, M.D.) use and disclosure of your protected health information to carry out treatment, payment, or healthcare operations. For a more complete description of such uses and disclosures, please refer to our Notice of Privacy Practices.

You have the right to review our Notice of Privacy Practices prior to signing this consent. However, we reserve the right to change our privacy practices, and change the terms of the notice. Any new notice provisions will be effective for all protected health information that we maintain. Should you wish to obtain a revised notice, you may contact our privacy officer.

You have the right to request that (Raffi Karapetian, D.O., V. Stephen Slana, M.D.) restrict how we use and disclose your protected health information. We are not required to agree to such a restriction, but if we do the restriction will be binding on us. If we do agree, we will restrict our use and disclosure to the extent we document such writing and notifying you of the same.

You have the right to revoke this consent in writing at any time, except that (Raffi Karapetian, D.O., V. Stephen Slana, M.D.) has acted in reliance on it.

I UNDERSTAND AND AGREE TO THE FOREGOING:

_____ _____

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE **DATE**

_____

(RELATIONSHIP TO PATIENT)

YOU ARE ENTITLED TO A COPY OF THIS SIGNED CONSENT FORM UPON REQUEST