CONSENT TO USE/OR DISCLOSURE OF PATIENT INFORMATION

As a patient of Puget Sound Eye Care, you have the right to know how we may use and disclose information about you. Information about this is provided in our **Notice of Privacy Practice**.

You have the right to review our Notice of Privacy Practice before signing this form. A copy of this notice is available to you for your review at the front reception desk. We may change our Notice of Privacy Practice at any time. You may request a paper copy of our current Notice of Privacy Practice.

You should read our Notice of Privacy Practice carefully before signing this form. As our Notice of Privacy Practice explains, we need your consent to use or disclose information about you so that we can provide you with health care treatment; arrange payment for your care; and conduct certain kinds of administrative health care operations. By signing this **CONSENT TO USE/OR DISCLOSURE OF PATIENT INFORMATION**, you agree that we may use or disclose information about you for these purposes.

You have a legal right to request us not to use or disclose information about you for some kinds of treatment, payment or health care operations purposes. We are not legally required to grant this kind of request. We are only bound by a request for additional information if we agree to them in writing. Please contact our Privacy and Public Information Officer if you want more information or to revoke this consent.

By signing below you agree that we may use information about you for purposes of providing treatment, arranging payment, and health care operations.

____ ____________________
PATIENT NAME: (PLEASE PRINT) DATE

____ ____________________
PATIENT OR LEGALLY AUTHORIZED INDIVIDUAL SIGNATURE DATE

____ ____________________
PRINTED NAME IF SIGNED ON BEHALF OF THE PATIENT RELATIONSHIP