Wichryk Eye Associates, P.C.

Patient Consent for Use and Disclosure

of Protected Health Information

This acknowledgment and consent describes how medical information about you may be used and disclosed and how you can get access to this information.

Our Notice of Privacy Practices

By Law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of privacy Practices, we will post the new one in our office and have copies available in our office.

I have received the Notice of Privacy Practices for Wichryk Eye Associates, PC and hereby give my consent to use and disclose protected health information about _____ (patient name) to carry out treatment, payment and health care operations. The Notice of Privacy Practices provided by Wichryk Eye Associates describes such uses and disclosures more completely. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Wichryk Eye Associates may decline to provide treatment to me.

Due to HIPAA regulations, please list any authorized person(s) with whom we can discuss your appointments, insurance and/or payments.

Name of Authorized Person(s):	Relationship to Patient:	Phone Number:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Name (print): _____

Signature of Patient or Legal Guardian: _____

Date: _____