Consent for the Use or Disclosure of Protected Health Information

The Kentucky Center for Vision

120 N. Eagle Creek Drive, #431

Lexington, KY 40509

As required by the Health Information Portability and Accountability Act of 1996, The Kentucky Center for Vision may not use your personal health information for the purposes of treatment, payment or health care operations. The specific uses and disclosures that we intend to make are described in our Notice of Information Practices. You have the right to review the Notice of Information Practices prior to signing this consent form. You may request restrictions on the uses and disclosures described in the notice of information practices by describing the requested restrictions in the "restriction request" section of this form.You may revoke this consent at any time by signing and dating the revocation section on your copy of the form and returning it to this office.

CONSENT SECTION

I, ______________________________ (print name) hereby consent to the use and disclosure of my personal health information for the purposes or treatment, payment and health care operations. My signature below indicates that I have been given an opportunity to read The Kentucky Center for Vision's Notice of Information Practices and to have any questions answered before signing.

I understand that I may request restrictions on the uses and disclosures of my health information at any time by completing and signing the restriction request section of this form. I further understand that The Kentucky Center for Vision is not required to accept my restriction request.

I understand that I may revoke this consent at any time by signing the revocation section of my copy of this form and returning it to The Kentucky Center for Vision. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this consent.

____________________________ ______________________________

Signature Date

RESTRICTION REQUEST SECTION

I hereby request the following restrictions in the uses and disclosures of my health information (please describe the requested restriction in detail):

Signature	Date

REVIEWER SECTION

The terms of this request are/are not (circle one) acceptable.

Signature	Date
Print Name	Title

Reviewer's Comments:

REVOCATION SECTION

I hereby revoke this consent.

Signature	Date