DIAMOND VISION EYE CENTER
CONSENT FOR RELEASES OF
PROTECTED HEALTH INFORMATION

I, _____, CONSENT TO THE RELEASE OF PROTECTED HEALTH INFORMATION THAT IS REQUIRED TO CARRY OUT TREATMENT AND PAYMENT OF HEALTHCARE OPERATIONS ON MY BEHALF.

I HAVE READ THE NOTICE OF PRIVACY PRACTICES AND AM AWARE OF THE FOLLOWING:

- I HAVE THE RIGHT TO PLACE RESTRICTIONS ON THE WAY MY PROTECTED HEALTH INFORMATION IS USED OR DISCLOSED.
- I UNDERSTAND THAT *DIAMOND VISION EYE CENTER* IS NOT REQUIRED TO AGREE WITH MY REQUESTED RESTRCTIONS. I ALSO UNDERSTAND THAT ONCE *DIAMOND VISION EYE CENTER* AGREES TO MY RESTRICTIONS, IT MUST COMPLY WITH THOSE RESTRICTIONS.
- I HAVE A RIGHT TO REVOKE MY CONSENT FOR THE USE AND DISCLOSURE OF MY PROTECTED HEALHT INFORMATION AT ANY TIME. I UNDESTAND THAT, IF I CHOOSE TO REVOKE MY CONSENT, I MUST SUBMIT A WRITTEN STATEMENT THATIS SIGNED BY ME.
- I UNDERSTAND THAT *DIAMOND VISION EYE CENTER* MUST IMMEDIATELY COMPLY WITH MY REQUEST TO REVOKE CONSENT, EXCEPT TO THE EXTENT THAT HAS ALREADY TAKEN SOME ACTION THAT WAS BASED ON MY ORIGINAL CONSENT.
- DIAMOND VISION EYE CENTER HAS RESERVED THE RIGHT TO CHANGE FROM TIME TO TIME OUR PRIVACY PRACTICES THAT ARE DESCRBIED IN THE NOTICE OF PRIACVY PRACTICES.
- WHENEVER WE CHANGE OUR PRACTICES WE WILL MODIFY THE NOTICE ACCORDINGLY AND WILL INFORM YOU BEFORE YOU ARE TREATED AT THE OFFICE.

INDIVIDUAL:	WITNESS:
_____	_____
PRINTED NAME	PRINTED NAME
_____	_____
SIGNATURE	SIGNATURE
_____	_____
DATE	DATE