HIPAA CONSENT

Permission to Use and Disclose my Health Information: By signing this form, I give Clarendon Vision Development Center permission to use and/or disclose my health information to provide treatment, obtain payment and/or conduct health care operations.

Right to Refuse: I have the right not to sign this consent. If I refuse to sign this consent, Clarendon Vision Development Center has the right to refuse to treat me. However, treatment required by law – such as emergency care – can be provided to me whether or not I sign this consent.

Right to Review Notice of Privacy Practices: I have been provided with a copy of the Notice of Privacy Practices for Clarendon Vision Development Center which describes how Clarendon Vision Development Center may use and disclose my health information. I have the right to review this Notice before signing this consent.

Changes to the Notice of Privacy Practices: Clarendon Vision Development Center may change the Notice of Privacy Practices as needed. I may obtain a current copy of the Notice of Privacy Practices for Clarendon Vision Development Center by contacting Clarendon Vision Development Center via email.

Right to Request Restrictions on Use/Disclosure: I have the right to request that the usage of my protected health information by Clarendon Vision Development Center be restricted in how it is used and/or disclosed for the purpose of providing treatment, obtaining payment and/or conducting health care operations.

Right to Withdraw Consent: I have the right to withdraw this consent at any time. I must do so in writing by contacting Clarendon Vision Development Center at 760 Pasquinelli Drive, Suite 300, Westmont, IL 60559. My withdrawal of this consent will not be effective for uses and/or disclosures that have already been made based on my prior consent. If I withdraw this consent, then Clarendon Vision Development Center may refuse to provide to me further treatment or follow-up, other than required emergency services.

Effective Period: This consent is good unless and until I withdraw it in writing.

References to “I” or “me”: References to “I” or “me” in this Consent include the individual for whom the signing party is authorized to sign. If I am signing this consent on behalf of another person, it is because I am the person’s parent, legal guardian, or agent under an active Power of Attorney for Health Care; and I am legally authorized to sign this Consent on behalf of that person.

____ ________________________________
Signature of patient or authorized representative Date

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Print name of patient or authorized representative