



I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by Golden State Eye Medical Group (GSEMG) of its Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that GSEMG has the right to change its Notice of Privacy Practices from time to time and that I may contact GSEMG at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that GSEMG restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the GSEMG is not legally required to agree to my requested restrictions, but if GSEMG agrees, then GSEMG is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that GSEMG has taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____