**Patient Consent for Use and Disclosure**

**of Protected Health Information**.

 I hereby give my consent for **Designs for Eyes** to use and disclose protected health information (**PHI**) about me to carry out treatment, payment and health care operations (**TPO**).

I have the right to review the Notice of Privacy Practices prior to signing this consent **Designs for Eyes** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Designs for Eye**.

With this consent, **Designs for Eyes** may call my home or other alternative location and leave a message on voicemail or person in reference to any items that assist the practice in carrying out **TPO**, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent **Designs for Eyes** may mail to my home or other alternative location any items that assist the practice in carrying out **TPO**, such as appointment reminder cards and patient statements.

With this consent **Designs for Eyes** may email to my home or other alternative location any items that assist the practice in carrying out **TPO**, such as appointment reminder cards and patient statements. I have the right to request that **Designs for Eyes** restrict how it uses or disclosed my **PHI** to carry out **TPO**. The practice is not required to agree to my request restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **Designs for Eyes** to use and disclose my **PHI** to carry out **TPO**.

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, **Designs for Eyes** may decline to provide treatment to me.

Signature of Patient or Legal Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Patient’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name of Parent or Legal Guardian if applicable

**Patient Info Sheet**

**Printed Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City/Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Appointment confirmations, recalls and eyeglasses/contact lens order**

**notifications are sent via Email, Text or Phone Call.**

**Your information is private, secure and only used for the purposes listed above*.***

**Email address**    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cell Phone (TEXT)**    **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(note “HOME” if you prefer a call.)**

**Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Designs for Eyes 1794 N Old US 23, Howell MI 48843   810.632.7444**