

Drs. Record, Record and Associates, Optometrists, PC  
1450 Sachem Place, Suite 202  
Charlottesville, VA 22901

Drs. Record, Record and Associates, Optometrists, PC  
600 Peter Jefferson Pkwy, Suite 390  
Charlottesville, VA 22911

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## CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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### SECTION A: PATIENT GIVING CONSENT

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

Patient Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

### SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Deborah Bates  
Telephone: (434) 978-4090  
Fax: (434) 978-1005  
Email: drrecord1450@yahoo.com  
Address: 1450 Sachem Place, Suite 202, Charlottesville, VA 22901

Contact Person: Monica Tracey  
Telephone: (434) 975-2420  
Fax: (434) 979-0500  
Email: drrecordpjp@yahoo.com  
Address: 600 Peter Jefferson Pkwy, Suite 390, Charlottesville, VA 22911

**Right to Revoke:** You will have the right to revoke the Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

### SIGNATURE

I had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*If this Consent is signed by a personal representative on behalf of the patient, complete the following:*

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.**

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### REVOCAION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information, payment activities, and healthcare operations. I understand that revocation of my Consent will *not* affect any action you took in reliance of my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_