BARIBEAU
CATARACT
AND
LASER
Dr. Alan D. Baribeau
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Patient Consent Form for Use and Disclosure of Protected Health Information HIPPA

By signing this Consent Form, you give us permission to use and disclose protected health information about you for treatment, payment, and healthcare operations except for any restrictions specified below to which we have agreed. *Protected Health Information* is individually identifiable information we create or receive, including demographic information, relating to your physical or mental health, to provision of healthcare services to you, and to the collection of payment for providing healthcare services to you.

Our Notice of Privacy Policies provides information about how we may use and disclose protected health information about you. As provided in our Notice, the terms of the Notice of Privacy Policies may change. If we change our Notice, you may obtain a revised copy by contacting our information privacy official, Tanya Wolff at 210-692-8888, who is also available to respond to any questions or receive any complaints you may have concerning your protected health information.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or healthcare operations. We are not required to agree to any restrictions, but if we do, we are bound to our agreement. If you wish to make a restriction, please submit your request and specific restriction(s) in writing to our office staff.

If you do not sign this Consent Form, we have the right to refuse your treatment unless a licensed healthcare professional has determined that you may require emergency treatment or we are required by law to treat you. We are required to document any circumstances in which we do not obtain your consent, yet carry out treatment. We will offer you a copy of this documentation should you decide not to sign this Consent Form. You have the right to revoke this Consent Form, in writing, except where we have already made disclosures in reliance on your prior consent.

Please list the people that we MAY disclose YOUR protected health information to:

_____	_____
Name	Relationship to Patient
_____	_____
Name	Relationship to Patient
_____	_____
Name	Relationship to Patient
_____	_____
Name	Relationship to Patient

By signing this Consent Form, you acknowledge that you have received a copy of the "Notice of Privacy Policies" and that you have read and understand those policies.

Patient Signature: _____ Date: _____