Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **Henry Vision Center, LLC** to use and disclose protected health information about me to carry out treatment, payment and healthcare operations.

Henry Vision Center, LLC's Notice of Privacy Practice provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Henry Vision Center, LLC** reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Henry Vision Center, LLC's** privacy officer at 3656 Hwy 138 SE Stockbridge, GA 30281.

With this consent, **Henry Vision Center, LLC** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, **Henry Vision Center, LLC** may mail to my home or other alternative location any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this constant, **Henry Vision Center, LLC** may e-mail to my home or other alternative location any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment remainder cards and patient statements. I have the right to request that **Henry Vision Center, LLC** restrict how it uses or discloses my protected health information to carry out treatment, payment and healthcare operations. However, the practice is not required to agree to my requested restriction, but if it does, it is bound by this agreement.

By signing this form, I am consenting to **Henry Vision Center, LLC's** use and disclosure of my protected health information to carry out treatment, payment and healthcare operations.

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, **Henry Vision Center, LLC** may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian