ASSOCIATED OPHTHALMOLOGISTS, S.C.
IMPERIAL OPTICAL

219 N HAMMES AVE.
JOLIET, IL 60435
(815) 741-3220

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Pursuant to the requirements found in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the following is offered for your information and consent. Please be aware that it is this office's policy to require your reading and signing this consent form prior to the provision of treatment or any other medical services. If you have any questions, please ask for the Private Official in this office.

I,_____currently reside at (address) _____
Of (city)_____, Illinois, do hereby consent to the use and disclosure of my individually identifiable health information ("Health Information") by Associated Ophthalmologists, S.C. and Imperial Optical ("Provider") for the purpose of providing treatment to me, receiving payment from responsible parties for health care services rendered by Provider, and/or engaging in health care operations, such as office management, credentialing case management, and quality assessment.

I understand that Provider's Notice of Privacy practices ("Notice") describes in more detail the types of uses of disclosure of Health Information involved in treatment, payment or health care operations, and that I have a right to review such Notice prior to signing this consent.

I understand that Provider has reserved the right to change its privacy practices as described in the Notice. In the event of any change in the Provider's privacy practices, Provider will revise the Notice. I understand that I can obtain a copy the revised Notice by writing to the Provider.

I understand that if I choose not to sign this consent, Provider may withhold medical services, other than emergency services.

I understand that I have the right to request a restriction on Provider's use or disclosure of any and/all Health Information to any/or all locations, entities or persons, I further understand that Provider is not obligated to agree to my request. However, if Provider does agree to my request, the agreement will become binding.

I understand that I have the right to revoke this consent, in writing, at any time, except to the extent that Provider has relied on this consent, and that any revocation will become effective on the date it has been received by Provider and will apply to uses and disclosures of Health Information after the date of receipt.

Dated this_____day of_____, 20____

_____
Signature of Patient

_____
Signature of Parent (of minor child) or Legal Guardian