ADVANCED FAMILY EYE CARE

You have certain rights regarding the information we maintain about you. These rights include:

The right to inspect and copy	The right to request restrictions
The right to amend	The right to a paper copy of this notice
The right to an accounting of disclosures	The right to request confidential communications

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. Advanced Family Eye Care may condition treatment upon the execution of this consent.

Additionally, by signing this form, you acknowledge that by presenting yourself as a patient or child you consent for vision and medical eye care by the doctors and staff of Advanced Family Eye Care. You hereby grant full authority to the optometrists/ophthalmologists and their respective assistants to administer and perform any and all drugs, treatments, tests, or diagnostic procedures to or upon me which may be advised or necessary.

This information and Notice of Privacy Practices is made available on request.

Patient_____ **Social Security** _____

Signed By:_____ **Date:**_____
Patient or Representative

Relationship (If other than Patient_____

Witness: _____

Date of last Revision: 11/11/2011
Effective Date: 11/11/2011