Miramar
EYE INSTITUTE

Surgery and Diseases of the Eye **Kenneth O. Karp, M.D.**

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: Patient Giving Consent

NAME: _____

ADDRESS: _____

TELEPHONE: _____SOCIAL SECURITY: _____

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 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 care information. A copy of our Notice accompanies this Consent. 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 to Privacy Practices, which will contain the changes. Those changes may apply to any of our protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practice, including any revisions of our Notice, at any time by contacting the Miramar Eye Institute:

Miramar Eye Institute **Telephone: 954-437-4316**
1951 S.W. 172nd Ave. Suite 301
Miramar, FL 33029

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

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent 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 care information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____