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CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Atlantic Eye Institute may use your health related information for the purposes of providing you with medical treatment, obtaining payment for services rendered and/or for general health care operations.

Your health related information may be submitted through the following mechanisms: US Mail, fax, internet, voice mail and/or personal communications. The most common entities that will receive this information are other providers, facilities, insurance companies, and pharmacies. More specific information pertaining to our practice policies is provided for you in our "Notice of Privacy Practices" statement. You have a right to review this statement prior to receiving health care and prior to signing this consent. The terms of our Notice of Privacy Practices may change, at any time. You may contact the office and request a revised policy. You may request that we restrict the use of health information for the purposes of treatment, payment and/or health care operations. Our physicians are not required to agree with the restriction. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, this information will not be restricted.

I have received a copy of the "Notice of Privacy" from Atlantic Eye Institute. I consent to the above noted terms related to the use and disclosure of my individually identifiable health information for the purposes of treatment, payment and/or health care operations. I understand that this consent will remain in effect for 6 years or until I revoke it in writing. I understand that Atlantic Eye Institute, upon request for my records, may have up to thirty (30) days from the date of the request to make the information available.

Patient Name (PRINT): _____ Date: _____

Patient (or Patient's Representative) Signature: _____

Responsibility of Patient's Representative to the Patient: _____

Patient Refusal: The patient or patient's representative has refused to sign the consent form

 Name of Patient or Patient's Representative

 Employee

 Date

Effective Date: 4/14/03
 Revised Date: 9/08