PATIENT CONSENT FORM

I (the patient) understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent, I authorize Baldwin Optical to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of Baldwin Optical's practice

I have also been informed of, and given the right to review and secure a copy of Baldwin Optical's ***Notice of Privacy Practices***, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA. I understand that Baldwin Optical reserves the right to change the terms of this notice from time to time and that Baldwin Optical may contact me at any time to deliver the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that Baldwin Optical is not required to agree to these requested restrictions. However, if Baldwin Optical does agree, they are then bound to comply with these restrictions.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

_____
Patient Name (print)

_____
Signature (must be 18 years or older)

_____
Relationship to Patient

_____
Date