RETINA AND VITREOUS ASSOCIATES OF KENTUCKY

PATIENT CONSENT FOR PURPOSED OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I hereby consent to Retina and Vitreous Associates of Kentucky using or disclosing my protected health information for purpose of providing treatment to me, obtaining payment for health care services rendered to me and to carry out the Practice's health care operations.

I understand that the Practice may condition its diagnosis or treatment of me upon my consent to allow its use or disclosure of my protected health information.

I acknowledge the Practice has provided me a copy of its **Notice of Privacy Practices**, which provides a more detailed description of the used an disclosures allowed by this consent. I acknowledge my right to review the Notice of Privacy Practices prior to signing this consent. The Practice reserves the right to change the privacy practices outlined in the Notice of Privacy Practices. I may obtain a revised copy by contacting the **Privacy Officer at 859-263-3900** or writing to **Retina and Vitreous Associates of Kentucky**
120 N Eagle Creek Dr, Suite 500 Lexington, KY 40509

I understand that I have the right to request on how the Practice uses and discloses my protected health information for treatment, payment or the health care operations. The Practice is not required to agree to any restriction, but if it does, the restriction is binding on the Practice.

I have the right to revoke this consent in writing, except to the extent that the Practice has taken action in reliance on this consent.

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Signature of Patient or Personal Representative

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Name of Patient or Personal Representative

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Date

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Description of Personal Representative's Authority