CONSENT FOR THE USE OF DISCLOSURE
OF PROTECTED HEALTH INFORMATION
THE COLORADO RETINA CENTER
274 UNION BLVD., SUITE 120, LAKEWOOD, COLORADO 80228

As required by the Health Information Portability and Accountability Act of 1996 The Colorado Retina Center may not use your personal health information for the purpose of treatment, payment or health care operations without your consent. The specific uses and disclosures that we intend to make are described in our Notice of Information Practices. You have the right to review the Notice of Information Practices prior to signing this consent form. You may request restrictions on the uses and disclosures described in the Notice of Information by describing the requested restrictions in the "restriction request" section of this form. You may revoke this consent at any time by signing and dating the revocation section on your copy the form and returning it to this office.

CONSENT SECTION

I, ___________________________________ (print name) herby consent to the use and disclosure of my personal health information for the purpose of treatment, payment and health care operations. My signature below indicates that I have given an opportunity to read The Colorado Retina Center's Notice of Information Practices, or it has been read to me, and to have any questions answered before signing. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by submitting a written request to the Colorado Retina Center.

I understand that I may request restrictions on the uses and disclosures of my health information at any time by submitting a request in writing. I further understand that The Colorado Retina Center is not required to accept my restriction request.

I also give my consent to The Colorado Retina Center staff and Dr. Mehta to leave messages regarding appointments, billing, test results and future treatment on my voicemail/answering machine or with persons taking my calls.

I understand that I may revoke this consent at any time by submitting a request in writing and returning it to The Colorado Retina Center. I further understand that any such revocation does not apply to the extent that a person authorized to use or disclose my health information have already acted in reliance of the consent.

____ __________________
Signature **Date**