Lakeway Eye Physicians and Surgeons, P.A.
Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Lakeway Eye Physicians and Surgeons, P.A. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

Lakeway Eye Physicians and Surgeons, P.A.'s Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Lakeway Eye Physicians and Surgeons, P.A. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Lakeway Eye Physicians and Surgeons, P.A. at 1007 RR 620 South, Suite 100, Austin, TX 78734.

With this consent, Lakeway Eye Physicians and Surgeons, P.A. may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Lakeway Eye Physicians and Surgeon, P.A. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as patient statements and letters as long as they are clearly marked in my name. I understand that postcards reminding me to schedule appointments may be mailed to my home or other alternative location unless I request otherwise.

I have the right to request that Lakeway Eye Physicians and Surgeons, P.A. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Lakeway Eye Physicians and Surgeons, P.A.'s use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Lakeway Eye Physicians and Surgeons, P.A. may decline to provide treatment to me.

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Signature of Patient or Legal Guardian | Print Name of Legal Guardian

_____ _____

Print Name of Patient | Date