Northern Wyoming Ophthalmology, P.C.
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"Eye, M.D."
Board Certified
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HIPPA PATIENT CONSENT FORM

The federal government requires all medical offices to make patients aware that they have the right regarding the use of their personal health information. Our Notice of Privacy Practices is available for your review at the front desk.

By signing this form, you consent to our use and disclosure of protected health information according to the Notice of Privacy Practices. You have the right to revoke this consent at any time, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in the reliance on your consent. Northern Wyoming Ophthalmology, P.C. provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

- We will not release information to any future doctor, attorney, life insurance company, without your written consent.
- Protected health information may be used for treatment through one of your current doctors, payments with your insurance company, or healthcare operations within our office.
- Northern Wyoming Ophthalmology reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the use of their information, but Northern Wyoming Ophthalmology does not have to agree to these restrictions if, for example it interferes with payment, daily operations, or providing quality care.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.

Patient Name:_____ Phone Number:_____

Cell Number:_____

May we leave messages/detailed medical on voicemail at either of these phone numbers? ___**Yes** ___**No**

Do you have any particular person that you authorize to receive and discuss information regarding your personal health information (general information, surgical and billing)? _____**Yes** ____**No**

NAME:_____ Relationship:_____

Phone Number:_____

SIGNATURE: _____ **DATE:**_____