Golden Gate Vision & Associates

Consent for Use & Disclosure for Health Information

Section A: Patient Giving Consent

Patient Name:_____ Patient Phone Number:_____

Patient Address:_____

E-mail:_____

Section B: To The Patient – please read the following statements carefully.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to only carry out treatment, payment activities and submissions of insurance.

Notice to Privacy Practices: You have the right to read your Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and health care operations. There is a copy posted in our waiting area. Upon request, we can issue you a copy of this policy.

You may obtain a copy from our office by contacting us at the following:

Telephone: (214) 387-4134 **Fax:** (972) 334-9743
Address: 7920 Preston Rd, Suite 200, Plano, TX 75024

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any prior action taken on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke the Consent.

Signature:
I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your office and disclosure of my protected health information to carry out insurance filing, treatment, and payment activity.

Payment is expected at the time services are rendered, including insurance co-payments. Please note that for your convenience we will bill your insurance company. If for any reason the insurance does not pay what is estimated, or delays payment more than sixty days, the balance will become the patient's responsibility. We will work with you to get your deserved benefits, but the patient and/or guardian is responsible for payment to this office.

_____ _____
Signature Date

_____ _____
Personal Representative's Name Relationship to Patient

You are entitled to a copy of this consent after you sign it, please ask.