Haywood
EYE AND VISION CARE

757 Old Norcross Road
Lawrenceville, GA 30046
Phone: (678) 442-1161

Mark G. Haywood, MD, LLC General Ophthalmology

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Haywood Eye and Vision Care, LLC to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Haywood Eye and Vision Care, LLC'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. Haywood Eye and Vision, LLC 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 Haywood Eye and Vision Care, LLC Privacy Officer at 757 Old Norcross Road, Lawrenceville, GA 30046.

With this consent, Haywood Eye and Vision Care, LLC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Haywood Eye and Vision Care, LLC may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Haywood Eye and Vision Care, LLC 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 Haywood Eye and Vision Care, LLC's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Haywood Eye and Vision Care, LLC may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Print Patient's Name Print Name of Patient or Legal Guardian