

CONSENT

**TO THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR
TREATMENT, PAYMENT, HEALTH CARE OPERATIONS,
AND AS OTHERWISE ALLOWED BY LAW**

Glaucoma Associates of Texas (hereinafter referred to as “Glaucoma Associates”) will maintain a record of the care and services you receive at Glaucoma Associates. This consent only covers your protected health information created while you are a patient of Glaucoma Associates. Your protected health information pertains to your diagnosis and/or treatment at Glaucoma Associates, including but not limited to information concerning mental illness (except for psychotherapy notes), use of alcohol or drugs or communicable diseases such as Human Immunodeficiency Virus (“HIV”), and Acquired Immune Deficiency Syndrome (“AIDS”), laboratory test results, medical history, treatment progress or any other such related information.

By signing this form, you consent to Glaucoma Associates’ use and/or disclosure of protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. Our *Notice of Protected Health Information Practices* provides information about how Glaucoma Associates and its physicians may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. **By signing this form, you also acknowledge that you have received a copy of Glaucoma Associates’ Notice of Protected Health Information Practices and an opportunity to review it before signing this consent.**

Signature of Patient or Legal Representative

Witness

Date