

Benefield Eye Care, PC  
14225 Dedeaux Rd  
Gulfport, MS 39503  
Notice of Privacy/Consent Form

I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers.

Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by Benefield Eye Care, PC, of the Notice of Privacy/Consent Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such **Notice of Privacy/Consent Form** from time to time and that I may contact this organization any time at the above address to obtain a current copy of the Notice of Privacy/Consent Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment of health care operations.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_

Relation to Patient \_\_\_\_\_