You may obtain a copy of this notice at any time by contacting:

Ridgedale Family Eye Care
256 Columbia Tpke, North Tower, Suite 211
Florham Park, NJ 07932
Tel: 973.301.0400
Fax: 973.301.8928

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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 action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this consent.

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 use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

Signature____Date:____________________

If a personal representative on behalf of the patient signs this consent please complete the following:

Personal Representative's Name____________________________

Relationship to the patient_________________________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

Include completed consent in patients chart.

Revocation of this consent:

I revoke my consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations

I understand that revocation of my consent will not affect any action you took in reliance of my consent before you received this written Notice of Revocation. I also understand that you may decline to treat or continue to treat me after I have revoked my consent.