

**EYE CENTER OF ST. AUGUSTINE
THE EYE SURGERY CENTER OF ST. AUGUSTINE
CONSENT TO RELEASE RECORDS AND
INFORMATION CONTEMPLATED BY HIPAA**

As a patient of **EYE CENTER OF ST. AUGUSTINE / THE EYE SURGERY CENTER OF ST. AUGUSTINE**, I recognize that the Health Insurance Portability and Accountability Act of 1996 (HIPAA), public law 104-191, constitutes a comprehensive act of protection to ensure the security and confidentiality of my protected health care and account information. I further recognize that **EYE CENTER OF ST. AUGUSTINE / THE EYE SURGERY CENTER OF ST. AUGUSTINE**, is maintaining protected health information and my patient account record with respect to my care and treatment.

By my signature appearing below, I agree, acknowledge, and understand that from time to time it will be necessary for **EYE CENTER OF ST. AUGUSTINE / THE EYE SURGERY CENTER OF ST. AUGUSTINE** to transmit certain information about my care, treatment, operations, payment and account to third parties so as to assist in my health care, to protect my health and well being, and to facilitate the timely and orderly billing and payment for the services I am receiving from **EYE CENTER OF ST. AUGUSTINE / THE EYE SURGERY CENTER OF ST. AUGUSTINE**.

With this acknowledgment and understanding in mind, and by my signature appearing below, I am specifically consenting to the release of electronic and other transmission of information with respect to treatment, payment, or health care operations regarding my care, treatment and services. **IF THERE IS ANYONE YOU DO NOT WISH TO RECEIVE YOUR INFORMATION, LIST HERE:**

I reserve the right to revoke this authorization and/or consent during the term of my care or, at any time, but acknowledge that such revocation of authorization will be required in writing and signed by me, dated, and delivered to **EYE CENTER OF ST. AUGUSTINE / THE EYE SURGERY CENTER OF ST. AUGUSTINE**.

Patient Signature: _____

Date: _____

REVISED 11/08

PATIENT NAME: SURGEON: DATE OF SURGERY:
