RASHID AND RICE EYE ASSOCIATES, PLLC
5430 Fredericksburg Road, Suite 100, San Antonio, TX 78229

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how Protected Health Information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent.

The federal privacy laws now limit our ability to communicate with your family and others who may participate in your medical care. Please list those individuals with whom you would allow us to share your health information, if necessary.

____ _______________________________
Person who may receive medical information Relationship

____ _______________________________
Person who may receive medical information Relationship

Patient's Name: ____________________________________ Date: ______________
(Print Your Name)

This Consent was signed by: ____
(Signature of Patient or personal representative)

Relationship to Patient (if other than patient):________________________________

Signed in front of ________________________(Printed name of Practice employee)