I GIVE MY PERMISSION TO DISCLOSE MY
☐HEALTH ☐FINANCIAL
INFORMATION TO THE FOLLOWING PERSONS:

	Relationship:
	Relationship:
	Relationship:
	Relationship:
	Relationship:

I have read the *Notice of Privacy Practices* and I have reviewed this consent form. I give my permission to *DAVIDSON EYE ASSOCIATES, P.A.* to use and disclose my health information in accordance with it. I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that when information is disclosed to others as a result of this authorization, DAVIDSON EYE ASSOCIATES, P.A. has no control how that information is used by them and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization. **This authorization shall be in effect until revoked by the patient.**

_____

Name of Patient (Print or Type)

_____

Signature of Patient or Legal Guardian if Patient is under 18 years old

_____

Date

_____

Relationship of Legal Guardian

revised 7-14-09