GLAUCOMA CENTER
OF TEXAS

CONSENT

TO THE USE AND / OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, HEALTH CARE OPERATIONS, AND AS OTHERWISE ALLOWED BY LAW.

Glaucoma Center of Texas (hereinafter referred to as "Glaucoma Center") will maintain a record of the care and services you receive at Glaucoma Center. This consent only covers your protected health information created while you are a patient of Glaucoma Center. Your protected health information pertains to your diagnosis and/or treatment at Glaucoma Center, including but not limited to information concerning mental illness (except for psychotherapy notes), use of alcohol or drugs or communicable diseases such as Human Immunodeficiency Virus ("HIV"), and Acquired Immune Deficiency Syndrome ("AIDS"), laboratory test results, medical history, treatment progress or any other such related information.

By signing this form, you consent to Glaucoma Center's use and/or disclosure of protected health information about you for treatment, payment, and health care operations and as otherwise allowed by law. Our *Notice of Privacy Practices* provides information about how Glaucoma Center and its physicians may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law.

By signing this form, you also acknowledge that you have received a copy of Glaucoma Center's Notice of Privacy Practices and an opportunity to review it before signing this consent.

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Patient's Signature (*or Authorized Representative/Guardian*) Patient Date of Birth

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Today's Date