TEXAS VISION THERAPY
Justin Chelette, OD FAAO
Developmental Optometrist

HIPAA CONSENT

Permission to Use and Disclose my Health Information: By signing this form, I give Texas Vision Therapy permission to use and/or disclose my health information to provide treatment, obtain payment and/or conduct health care operations.

RIGHT TO REFUSE: I have the right not to sign this consent. If I refuse to sign this consent, Texas Vision Therapy has the right to refuse to treat me. However, treatment required by law – such as emergency care – can be provided to me whether or not I sign this consent.

RIGHT TO REVIEW NOTICE OF PRIVACY PRACTICES: I have been provided with a copy of the Notice of Privacy Practices for Texas Vision Therapy which describes how Texas Vision Therapy may use and disclose my health information. I have the right to review this Notice before signing this consent.

CHANGES TO THE NOTICE OF PRIVACY PRACTICES: Texas Vision Therapy may change the Notice of Privacy Practices as needed. I may obtain a current copy of the Notice of Privacy Practices for Texas Vision Therapy by contacting the office via email.

RIGHT TO REQUEST RESTRICTIONS ON USE/DISCLOSURE: I have the right to request that the usage of my protected health information by Texas Vision Therapy be restricted in how it is used and/or disclosed for the purpose of providing treatment, obtaining payment and/or conducting health care operations.

RIGHT TO WITHDRAW CONSENT: I have the right to withdraw this consent at any time. I must do so in writing by contacting Texas Vision Therapy, 19002 Park Row Ste 203, Houston, Texas 77084. My withdrawal of this consent will not be effective for uses and/or disclosures that have already been made based on my prior consent. If I withdraw this consent, then Texas Vision Therapy may refuse to provide to me further treatment or follow-up, other than required emergency services.

EFFECTIVE PERIOD: This consent is good unless and until I withdraw it in writing. References to "I" or "me": References to "I" or "me" in this Consent include the individual for whom the signing party is authorized to sign. If I am signing this consent on behalf of another person, it is because I am the person's parent, legal guardian, or agent under an active Power of Attorney for Health Care; and I am legally authorized to sign this Consent on behalf of that person.

_____ _____

Signature of patient or authorized representative **Date**

_____

Print name of patient or authorized representative