Haik & Terrell, LLC
dba Haik & Terrell Eye Clinic

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(504) 833-5573

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P.O. Box 51, Luling, LA 70070
(985) 785-8444

CONSENT FORM FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Once you have consented to use and disclose of your protected health information for Treatment, payment and health care operations and signed the consent form below, your physician can use or disclose your protected health information as described in your Notice of Privacy Practices in accordance with United States government guidelines. Your protected health information may be used and disclosed by your physician, our office staff and others of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills.

You may request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposed as described in your Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

_____ X_____
Patient's Name (Print) Patient's / Parent's Signature

_____ X_____
Date I DO NOT Wish To Sign

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____acknowledge that Haik & Terrell, LLC Clinic has given me the Notice of Privacy Practices.

X_____
Patient's / Parent's Signature

_____
Date