Ophthalmology Associates
Kansal Eye, PLLC
770 N. Coit Road, Suite 2486
Richardson, Texas 75080

CONSENT FOR USE OF PATIENT INFORMATION

This consent is for disclosure of protected health information for the purpose of treatment, operations or payment.

I understand that the practice and/or doctor may need to use and disclose information about my health or medical problems for the purposes of arranging, conducting, or referring for my treatments, for obtaining payment for the services rendered me and for the operations of the practice. I consent to the use of my information for the purposes of treatment, payment and health care operations.

I understand that my **consent is not needed if the law requires the practice and/or doctor to report some aspect of my protected health information to a government agency.** Examples would include suspected abuse, driving capability, communicable disease and potential for serious bodily harm to myself or others.

I understand that I have the right to review the practice's privacy notice, to request restrictions on the use of my information and to revoke my consent at a later date.

I understand that if **I withhold consent** for the use of my information for the purposes of treatment, payment or operation, the practice and/or **doctor may decline to undertake my care.**

This agreement remains in effect for any visits with Kansal Eye, PLLC, unless otherwise revoked by the patient or authorized representative. Revoking this agreement will terminate any future patient-doctor relationship between the patient and Kansal Eye, PLLC or its staff. A copy of this signed form can be provided at any time.

_____	_____	_____
Printed Name	Signature	Date