# MOHAVE EYE CENTERS

## Consent for Use and Disclosure of Personal Health Information

This form authorizes us to use and disclose your protected health information (PHI) for the purposes of healthcare operations, treatment and payment activities.

Before signing, please read our Notice of Privacy Policies to gain a clear understanding of how we may use and discuss your (PHI).

For questions concerning our Notice of Privacy Policies, please contact Mohave Eye Centers:
Kingman (928) 753-2106     Bullhead City (928) 763-1000

### Patient's Consent

Patient Name:_____________________________

Address:_________________________________

City:______________________________________ State:_________________ Zip:______________

Telephone:__________________________________ E-mail:________________________________________

Patient#:___________________________________ Social Security Number________________________

I,________________________________________ have read your Notice of Privacy Policies and consent to your use of my (PHI) for the purposes of healthcare operations, treatment and payment activities.

Signature:______________________________________________________

If this form is signed by a personal representative on hehalf of the patient, complete the following Personal Representative Name:____________________________________________

Relationship to Patient:___________________________________________

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### Patients Revocation

By signing below, you revoke your above consent for us to use and disclose your (PHI). However, by doing so, we reserve the right to discontinue treatment for you. The revocation also does not negate any of our prior actions while acting under your consent.

Signature:______________________________________________________ Date:____________________

If this consent revocation is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:____________________________________

Relationship to Patient: ___________________________________________