

**HD Optical Express**  
5735 S. Cedar St. Ste.1  
Lansing, MI 48911  
(517) 882-2015

**Consent for Use and Disclosure of Health Information**

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your health information for the sole purposes related to carrying out treatment, payment activities, and/or health care operations. You will authorize HD Optical Express to share your medical information with other medical providers if you are referred to another medical provider for advanced care or to update your primary care provider and/or a referring doctor on your status. **You understand that you, the patient, are ultimately responsible for any balance not covered, as well as any co-payments and/or deductible.** You also authorize the release of medical information necessary to process your insurance claim to your insurance carrier(s).

**Notice of Privacy Practices:** You have the right to read the HD Optical Express Notice of Privacy Practices prior to signing this consent. Our Notice provides a description of our use and disclosure of your health care information related to treatment, payment activities, and health care operations.

**Right to Request Restrictions:** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations or to someone who is involved in your care or the payment for your care at any time by giving a written notice to the privacy officer listed below. Please understand that revocation of this consent will not effect any action we took on reliance to this consent before receiving your revocation. We are not required to agree to your request. You acknowledge that we may decline to treat you or continue to treat you if you request to revoke this consent.

We reserve the right to change our privacy practices as described in our Notice; changes to this notice will be added to and documented in an updated version of the HD Optical Express Notice of Privacy Practices. You may obtain a current copy of the HD Optical Express Notice of Privacy Practices at any time from our privacy officer.

**Privacy Officer: Dr. Daniel N. Nash, OD**  
5735 S. Cedar St. Ste.1  
Lansing, MI 48911  
(517) 882-2015

Patient Name: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Ste/Apt #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Social Security # (For Insurance Purposes Only): \_\_\_\_\_

**I have had the opportunity to read and consider the contents of the HD Optical Express Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health care information to carry out treatment, payment activities, and health care operations.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If this form is signed by a personal representative patient, please complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

You are entitled to a copy of this consent after you sign it.  
This consent form will be kept in your chart.