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Use and Disclosure of Protected Health Information

I understand that **Craig G. Hoover OD & Associate PLLC** may use and disclose my protected health information for purposes of treatment, payment, and health care operations. I also acknowledge that I have received, have been offered, or have received in the past a copy of the Practice's Notice of Privacy Practices, which provides information about how the Practice, and individuals involved in my care in the Practice, may use and disclose my protected health information. As provided in the Notice, the terms of the Notice may change. To obtain a current copy of any current Notice, I understand that I can contact the **Privacy Officer** at **(540) 825-0541**. I understand that I have the right to request that the Practice restrict how my protected health information is used or disclosed for treatment, payment or health care operations, but I also understand that the Practice is not required to agree to a requested restriction.

However, if the Practice does agree, it is bound by the agreement. I understand that I have the right to revoke this consent in writing at any time, except to the extent that the Practice, or individuals involved in my care in the Practice, have already used or disclosed protected health information in reliance on my prior consent.

Individual name: _____ **Date:** _____

Patient or authorized person's signature