BOSTON EYE CARE CONSULTANTS

Robert A. Lytle, MD

Notice of Health Information Privacy Rights

I, have been given adequate time to read or take with me Boston Eye Care Consultant's Health Information Privacy Rights(Located in the patient waiting room in RED BINDER), on the date of my signature below.

If I have questions in regards to the Boston Eye Care's policy, I may speak with the chief safety office, Dr. Robert Lytle.

I understand that my medical information contains or may contain highly confidential information. By my signature below, I specifically consent to the disclosure of such information to insurers and providers outside of this practice for the purpose of obtaining treatment for me, payment for the treatment provided to me, so that these entities can carry out their health care operations.

Please note any restrictions in the space below:

* Patient signature:________________________ * Name (printed):________________________

* Date:________________________

The signature of the patient, guardian, or personal representative must sign below if the patient is an emancipated minor or otherwise incapacitated, physically or mentally with the relationship noted next to the signature.

Signature:______________________________ Relationship:__________________________

Name:______________________________________ Date:____________________________