VSP Vision care for life

Patient Consent Form

Patient Name:_____ Date of birth: _____

I, _____Patient / Guardian of Patient_____, consent EyeCare Associates LLC Vision Source

to the release of medical records for the above specified individual to:

VSP
P.O. Box 997100
Sacramento, CA 95899-7100

PLEASE READ CAREFULLY: I understand that my medical records are confidential. I understand that by signing this consent form I am allowing my medical information to be released upon VSP's request, to VSP for the purpose of Health Care Operations (including, but not limited to, provider review functions, claim payments and quality assessment.) I also understand that I may revoke this consent by written request, at any time, with this doctor. If revoked, it is understood by all parties that all information release prior to being notified of such revocation was made with my consent.

For additional information on VSP's Patient Confidentiality Policy, please refer to ww.vsp.com. VSP updates the Patient Confidentiality Policy periodically and reserves the right to make changes and required.

I understand that I have the right to restrict the disclosure of specific information in my medical records if I request such restriction in writing. I also understand that my request for restriction may be denied if the information restricted is required for Health Care Operations.

I have read the above and foregoing consent for release of information. I do hereby acknowledge that I am familiar with and fully understand the terms and conditions of the consent.

_____ _____

Signature Date