Notice and Consent of the Lighthouse Low Vision Services Privacy Practices

- I consent to the use and disclosure by the Lighthouse Low Vision Services of individually identifiable health information for treatment, payment and/or health care operations only in ways that are consistent with provisions of the US department of Health and Human Services, Health Insurance Portability and Accountability Act (HIPAA).

- I acknowledge receipt of this Notice of Privacy Practices and understand that a full copy of the Lighthouse Low Vision Services Privacy Practices will be provided on request in a format that is accessible to me.

_____

Name of Client or Legal Representative

_____ _____

Signature of Client or Legal Representative Date