ATTACHMENT "B"

CONSENT

TO THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, HEALTH CARE OPERATIONS, AND AS OTHERWISE ALLOWED BY LAW

Texas Retina Associates (hereinafter referred to as "Texas Retina") will maintain a record of the care and services you receive at Texas Retina. This consent only covers your protected health information created while you are a patient of Texas Retina. Your protected health information pertains to your diagnosis and/or treatment at Texas Retina, including but not limited to information concerning mental illness (except for psychotherapy notes), use of alcohol or drugs or communicable diseases such as Human Immunodeficiency Virus ("HIV"), and Acquired Immune Deficiency Syndrome ("AIDS"), laboratory test results, medical history, treatment progress or any other such related information.

By signing this form, you consent to Texas Retina's use and/or disclosure of protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. Our *Notice of Protected Health Information Practices* provides information about how Texas Retina and its physicians may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. **By signing this form, you also acknowledge that you have received a copy of Texas Retina's Notice of Protected Health Information Practices and an opportunity to review it before signing this consent.**

_____ _____

Signature of Patient or Legal Representative Witness

_____

Date

HIPAA Authorization: I authorize the following person(s) to discuss my medical care and billing/insurance information with the Texas Retina Associates staff on my behalf:

Name _____ Relationship _____

Name _____ Relationship _____