# CONFIDENTIAL & PRIVACY RELEASE

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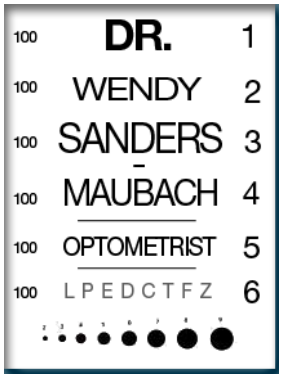


## Consent for Release and Use of Confidential Information Receipt of Notice of Privacy Practices

I, _____ , hereby give my consent to Dr. Sanders-Maubach,
(patient or guardian)

to user or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contain in the patient record of:

_____
(name of patient)

I acknowledge receipt of the Optometrist Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

I understand that the Optometrist has reserved the right to change the privacy practices that are described in the Notice. I, also, understand that a copy of any revised Notice will be provided to me upon request.

I understand the consent is valid until it is revoked by me. A written revocation of consent must be send to the Optometrist's office, at the address listed above. I also understand that I will not be able to revoke this consent in cases where the Optometrist has already relied on it to use or disclose my health information.

_____ _____
Patient's Signature Date

If not the patient, please indicate the relationship to patient. _____

Please list the name(s) of the person(s) that are authorized by you to pick up any products or information regarding the service provided to you by Dr. Sanders-Maubach.

_____ _____