Authorization Form

Patient: ____

Patient Phone Number: ____

Patient Address: ____

Purpose of Consent:
Signing this form, you are consenting to our use and disclosure of your protected health information to only carry out treatment, payment activities, and submitting insurance.
You are authorizing payment directly to Frisco Family Vision or its doctors. You are authorizing the signature on file to be used if you choose to pay for materials or services by credit card over the phone. Your credit card information will **NOT** be saved in our computer system. You will be authorizing that Frisco Family Vision has your signature on file.

Notice to Privacy Practices:
Before signing the consent form, you have the right to read the Notice of Privacy Practices. Upon request, we can issue you a copy of this policy for your records. We also have a copy posted in reception area.

You have the right to revoke this consent at any time by giving our office written notice submitted to our office address listed above. Please note that revocation of this consent will not affect any prior action taken on this consent before our office received the revocation; however, Frisco Family Vision can decline to treat you or continue any treatment if you revoke this consent.

I, ____, have had full opportunity to read and consider the contents of this consent form and the Notice of privacy practices. I understand that by signing this form, I am giving consent to this office and disclosure of my protected health information to carry out any insurance filing, treatment, and payment activity.

____ _________________
Patient/Guardian Signature Date

10150 Legacy Drive, Suite 300 - Frisco, TX 75033