7108 Camp Bowie Blvd.
Fort Worth, Texas 76116
Phone: (817) 738-3191
Fax: (817) 738-3103

Federal requirements regarding the privacy of the patient's health care information took effect in April 2003. H.I.P.A.A., the Health Insurance Portability and Accountability Act require that all health care providers and Insurance companies ensure that your personal medical information is safe.
Luck Optical requests that each patient sign this consent form, which allows us to share protected health information with our physicians, your doctor and insurance companies. By signing this form you consent to use and disclosure of protected health care operations. You have to right to revoke this consent in writing, except where we have already made the disclosures in accordance with your prior consent. Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent.

I hereby acknowledge that I have been presented with a copy of Luck Optical Notice of Privacy Practices.

Signature of Patient or Representative: _____Date_____

Name of Patient or Representative: _____Date of Birth_____

Authorization to Release Information to Family Member

Many of our patients allow family members such as their spouse, parents or others to call and request the results of testing and procedures. Under the requirements of H.I.P.A.A. we are not allowed to give this information to anyone without the patients consent. If you wish to allow your test results to be released to family members you must sign this form. Signing this form will only give consent to release prescriptions, contact lenses, and glasses to the family members indicated below. This consent form does not allow Luck Optical to release any other information to these family members.
You have the right to revoke this consent, in writing, except where we have already made disclosures in accordance with your prior consent.

I authorize Luck Optical to release my results and reports to the following individuals.

1. _____ Relation to Patient: _____ Date: _____

2. _____ Relation to Patient: _____ Date: _____

PATIENT NAME _____ **DATE** _____

PATIENT SIGNATURE _____