

**Bond Eye Associates****Consent for Release and Use of Confidential Information and  
Receipt of Notice of Privacy Practices****Pekin**

Corporate Office  
725 South 14th St.  
Pekin, Illinois 61554  
(309) 353-6660  
Fax (309) 353-7664

I hereby give my consent to Bond Eye Associates to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in my patient record.

I acknowledge receipt of the 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 physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available at the Business Office.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to this office. I also understand that I will not be able to revoke this consent in cases where the physicians have already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

**Peoria**

6800 N. Knoxville Ave.  
Peoria, Illinois 61614  
(309) 692-2020  
Fax (309) 692-2181

**Bloomington**

713 LAA Drive  
Bloomington, IL 61704  
(309) 662-3937  
Fax (309) 662-1205

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient Signature or Authorized Agent)

**MINOR PATIENTS (under 18 years of age)**

The above terms and signature is consent for the records and information

of \_\_\_\_\_  
(Name of Minor)