PATIENT PRIVACY INFORMED CONSENT (HIPAA)

I have been informed and I consent to the release of my medical information in compliance with federal HIPAA regulations. My medical information will only be released to other medical providers for continuity of care and insurance companies in order to get my medical/ drug claims reimbursed. Any insurance company or companies involved in the reimbursement of my medical, drug or routine vision care will be based on all the insurance information that I provide. I understand that my patient information and diagnoses will be forwarded to these entities to facilitate continuity of care and to get claims paid. Wolstan & Goldberg Eye Associates practices a minimum information disclosure policy, and only necessary information will be forward to the entities.

I understand that Wolstan & Goldberg Eye Associates reserves the right to change their privacy notice and make changes effective for all personal health information they may have concerning me. If any changes occur, Wolstan & Goldberg Eye Associates has agreed to provide me with a revised copy upon my request.

I authorize Wolstan & Goldberg Eye Associates and staff to release my health information for these purposes.

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

In compliance with the HIPAA Patient Privacy Policy, you must choose one of the two options listed below:

- ❑ No information may be left with anyone but the patient. Please understand that by checking this box, **you are NOT granting us permission** to communicate any information pertaining to the patient's care in any form (phone, mail, email, fax, in person) with anyone other than the patient and care entities permitted under HIPAA.

- ❑ I authorize Wolstan & Goldberg Eye Associates to release information regarding my medical history and treatment via phone, mail, email, fax, or in person, to the person(s) listed below:

_____

Name & Relationship to Patient

_____

Name & Relationship to Patient

_____ _____

Signature Date

_____

Print Name

Name of patient if different from above:_____

If not signed by the patient, please indicate relationship:

❑ Parent of minor ❑ Guardian of minor ❑ Conservator of patient