Dietlein Eye & Laser Center

PATIENT PRIVACY INFORMED CONSENT (HIPPA)

I have been informed, and I consent, to the release of my medical information, in compliance with the Federal HIPPA regulations. My medical information will only be released to business associates and insurance companies for continued medical care, and in order to get my medical claims reimbursed. Examples of business associates include but not limited to St. David's Georgetown Hospital, Hill Country Surgery Center, Oakwood Surgery Center, Williamson Surgery Center, Scott & White Healthcare, Clinical Pathology Associates, Austin Radiological Associates, Austin Retinal Associates, Medicare, Blue Cross and any insurance company involved in the reimbursement of my medical expenses. I do understand that my patient information will be forwarded to these entities only to get claims paid, and to facilitate continuity of care. Our office strictly practices a minimum information disclosure policy, and only necessary information will be provided to these entities.

I also understand that our office reserves the right to make changes to our privacy notice and to make such changes effective for all personal health information we may already have about you. If this notice is changed we will post a copy in our office and provide you with a revised copy upon request.

I authorize Dietlein Eye Center and staff to release my information for these reasons.

Signature: X_____Date:_____

MEDICARE DISCLOSURE OF INFORMATION

I hereby authorize Novitas Solutions Medicare to furnish to my medical providers at Dietlein Eye Center, any information obtained to the adjudication of any claims in regard to services furnished to me under Title XVIII of the Social Security Act.

Signature: X_____Date:_____

I authorize Dietlein Eye Center and staff to release my information to the following people, for the following reasons:

Name: _____Reasons:_____

Name: _____Reasons:_____

Name: _____Reasons:_____

Name: _____Reasons:_____