Marciano Family Vision Associates

A MEMBER OF Vision Source™

DR. MARK MARCIANO, OPTOMETRIST · DR. BRANDEE O. MARCIANO, OPTOMETRIST · DR. MICHAEL HAUGEN, OPTOMETRIST

CONSENT TO RELEASE MEDICAL INFORMATION

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations. As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients) and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

I, _____ give my consent to Marciano Family Vision Associates to release
(Print Patients Name)
medical conditions, test results, prescriptions, or medical records to the following individual(s). We will not honor disclosure of your medical information with anyone other than those stated without proper medical release forms on file.

1. _____ Relationship:_____

2. _____ Relationship:_____

or

_____ Do not release information to anyone but myself.

Patient Signature:_____Date:_____

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have read and received a copy of Marciano Family Vision Associates Notice of Privacy Practices as required by HIPAA regulations.

Name (Print)_____Signature:_____Date:_____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I have insurance coverage with the fore mentioned insurance and assign directly to Marciano Family Vision Associates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for all co-pays and/or co-insurance. I also understand that in the event that my insurance does not remit payment, I am responsible for any charges, whether paid or not paid by the insurance company. I, hereby, authorize the doctor to release all information necessary to secure the payment of benefits and authorize the use of my signature on all insurance submissions.

Signature:_____ Relationship to Party_____ Date:_____