Lee's Summit Family Eyecare

Patient Name: _____ Date of Birth: _____

Insurance Consent Form

I, _____ (self, parent or guardian), consent Wendy K. Parsons, OD, PC to release my medical records to my insurance company.

I understand that my medical records are confidential. I understand that by signing this consent form I am allowing my medical information to be released, at my insurance companies request, to my insurance company for the purpose of Health Care Operations (including, but not limited to, provider review functions, claims payment and quality assessment). I also understand that I may revoke this consent by written request, at any time, with this doctor. If revoked, it is understood by all parties that all information released prior to being notified of such revocation was made with my consent.

I understand that I have the right to restrict the disclosure of specific information in my medical records if I request such restriction in writing. I also understand that my request for restriction may be denied if the information restricted is required for Health Care Operations.

_____ _____
Signature Date

HIPAA Acknowledgment

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by signing this form. We look forward to seeing you again soon!

I have read and understand the Notice of Privacy Practices of Lee's Summit Family Eyecare (Wendy K. Parsons, OD, PC).

_____ _____
Signature Date