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 claims reimbursed. Examples of medical providers may include but are not limited to: Eye Lasik Of Austin, M.D., Clinical Pathology Associates, Texas Oculoplastics, and Austin Retina Associates. Any insurance company or companies involved in the reimbursement of my medical/routine vision care will be based on all the insurance information I provide. I do understand that my patient information and diagnosis will be forwarded to these entities to facilitate continuity of care, and to get claims paid. River Place Vision Center practices a minimum information disclosure policy, and only necessary information will be forwarded to these entities.

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

I authorize River Place Vision Center and Dennis Smith, O.D., and his staff to release my health information for these purposes.

Patient or Guardian Signature: _____ Date: _____