# Blue Springs Family Eyecare

## Insurance Consent Form

Patient Name: _____ Date of Birth: _____

I, _____ (self, parent or guardian), consent Wendy K. Parsons, OD, PC, and/or Chelsea A. Scriven, OD, 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 company's 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; Chelsea A. Scriven, OD).***

*Signature* _____ *Date* _____

### Consent for Release of Medical Information

Due to HIPAA regulations, we will not be able to discuss any of your medical care and/or treatments with anyone for any reason unless you have authorized us to do so. In order to have such authorization, please select from the following:

***[ ] I authorize the release of information including medical care and treatments, medical rocords and/or examinations rendered to me, and insurance claims information***

NAME _____ RELATIONSHIP _____

NAME _____ RELATIONSHIP _____

NAME _____ RELATIONSHIP _____

NAME _____ RELATIONSHIP _____