Center for Health and Vision

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PATIENT PRIVACY INFORMED CONSENT (HIPAA)

The Center for Health and Vision respects and protects our patients' privacy. We have available, upon request, a complete explanation and Notice of Privacy Practices.

I understand that I am entitled to receive a copy of the Privacy Practices document upon request. I have been informed, and I consent, to the release of my medical information, in compliance with the Federal HIPAA 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 are not limited to, Hospitals, Surgery Centers, Radiology and Clinical Laboratory facilities, Medical Billing Associates, and Insurance Companies such as Medicare, Blue Cross/ Blue Shield, and/or any insurance companies involved in the reimbursement of my medical expenses. I understand that my patient information will be forwarded to these entities only to get claims paid, and to facilitate continuity of care. The Center for Health and Vision strictly practices a minimum information disclosure policy, and only necessary information will be provided to these entities.

I also understand that the Center for Health and Vision reserves the right to make changes to the privacy notice, and to make such changes effective for all personal health information they may already have about me.

I authorize Kenneth L. Malamud, M.D., PLLC and his staff to release my information for these reasons.

Signature:_____ **Date:**_____

Patient Name (Please Print):_____

MEDICARE DISCLOSURE OF INFORMATION

I hereby authorize Trail Blazers Medicare to furnish to Kenneth L. Malamud, M.D., PLLC, who is my medical provider, 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 Dr. Malamud and his staff to release my information to the following people for the following reason:

Name:_____ Reason:_____

Name:_____ Reason:_____

Name:_____ Reason:_____