HIPAA

IC Laser Eye Care

Dear Patient,

HIPAA(Health Insurance Portability and Accountability Act) requires our offices to obtain your permission to use or disclose your health information.

As you know, we create paper and electronic medical records about your health and the services that we provide to you. We understand that your medical information's personal to you and we are committed to protecting that information for you. Healthcare professional, including doctors, nurses and technicians may access your demographic information for the purposes of providing you care.

Your signature on this consent gives our office permission to preform any tasks including but not limited to:

- Bill your insurance company
- Call or escribe Prescriptions to your pharmacy
- Contact you by phone or mail to confirm or remind you of your appointments.
- Relay test result information to you over the phone, by mail , or over the phone as a message left on an answering machine.
- Speak with any professional provider regarding your medical condition if warranted for coordination of care.
- Communicate with the following family members:

Name:_________________________________ Relationship_________________
Phone Number:__________________________
Name:_________________________________ Relationship___________________
Phone Number___________________________

I Acknowledge the practice has a notice of privacy practices that I may review.
I have read the above health information disclosure guidelines and agree to them without restriction.

Thank you for allowing us the opportunity to participate in your healthcare.
Signature of Patient/
Parent____
Date______________________

Print Name of Patient____

3046 Knights Road
Bensalem, PA 19020
Tel. 215-639-4500

1725 Klockner Road
Hamilton, NJ 08690
Tel. 609-586-6700

2301 E. Alleghany Avenue
Philadelphia, Pa 19134
Tel. 215-291-2194

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