bella vision
FAMILY VISION CARE

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Patient Consent For Treatment & Authorization To Release Medical Information For Assignment Of Health Insurance Benefits

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Health Insurance Portability And Accountability Act (HIPAA) Consent

I consent to the use or disclosure of my protected health information (PHI) by Bella Vision LLC for the purpose of treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, Bella Vision can refuse to treat me.

I UNDERSTAND:

- I have been informed that Bella Vision, LLC has prepared a notice, which fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I have the right to review such notice prior to signing the consent.
- I have the right to request a restriction as to how my PHI is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Bella Vision, LLC is not required to agree to the restrictions that I may request, but if we do, we are bound by it.
- I have the right to revoke this consent, in writing, at any time, except to the extent that Bella Vision, LLC has taken in reliance on this consent.
- I understand that Bella Vision, LLC reserves the right to change their privacy practices and that I can obtain such changed notice upon request.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. Bella Vision, LLC provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPAA).

Full Name of Patient _____ Date _____

Signature of Patient/Parent/Guardian _____

Print Form