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Optometrist

Dr. Melinda Wells

HIPAA – Consent and Disclosure of Health Information

I understand that as a part of my healthcare, this office maintains a record describing my health history, diagnosis, test results and plans for treatment. I understand that this record is used as:

A basis for planning my care and treatment
A source of information to aid communication between my healthcare professionals if needed
A source of information to aid third party payers to verify that services were rendered and billed properly
A source of information to assess quality and review of care rendered in the office of Dr. Melinda Wells

I understand that I have a right to review my records. I also have the right to review the Notices of Privacy Practices as stated by federal law.

This document also serves as an official request to authorize release of my record or prescriptions to aid in my treatment.

_____ _____

Signature of Patient, Guardian, or Representative Date

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I have chosen to decline consent of this form, but acknowledge being informed of my rights