PATIENT CONSENT FORM

HIPAA Privacy Regulations. National rights to control release of your records, requires consent from you, before Star Vision Center can make routine or non-routine disclosures (for health care delivery, including treatement and payment) to your insurance carrier.

Patient Name:_____Date of Birth:_____

I, _____, consent Carol Starling, O.D. to the release of medical

records for the above specified individual to _____.
(insurance carrier)

PLEASE READ CAREFULLY: 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 upon my insurance carrier's request, to my insurance carrier 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.

COMMUNICATING: About appointments, insurance eligibility and information related to purchases. This may be done by telephone or postcard. If you require that we use a particular method to communicate with your in order to preserve confidentiality, please specify your method in writing to Dr. Carol Starling, at Star Vision Center.

I have read the above and foregoing consent for release of information. I do hereby acknowledge that I am familiar with and fully understand the terms and condition of the consent.

Signature: _____Date: _____
(patient or parent/guardian)