DELLO RUSSO LASERVISION

DELLORUSSO LASERVISION

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HIPPA Consent

1. Acknowledgement of Privacy Practice Notice

I have received a copy of the Dello Russo Laser Vision Notice of Privacy Practices

_____ _____ _____ _____

Patient's Name *DOB* *Signature of Patient/Parent/Guardian* *Date*

2. Designation of Certain Relatives, Close Friend and Other Caregivers

[ ] Initial [ ] Update

I agree that Dello Russo Laser Vision may disclose certain portions of my health information to a family member, close friend and other caregiver because such person is involved with my health care or payment relating to my health care. In that case, Dello Russo Laser Vision will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care

[ ] I wish to make no designation at this time.

_____ _____

Signature of Patient/Parent/Guardian *Date*

I designate the following persons listed below as persons involved with my health care or payment relating to my health care for the purpose of Dello Russo Laser Vision making the limited disclosures described above. (I understand that I am not required to list anyone. I also understand that I may change this list at any time in writing.)

Print Name: _____ Last 4 digits of his/her SS# (required) _____

Print Name: _____ Last 4 digits of his/her SS# (required) _____

Print Name: _____ Last 4 digits of his/her SS# (required) _____

Print Name: _____ Last 4 digits of his/her SS# (required) _____

Print Name: _____ Last 4 digits of his/her SS# (required) _____

_____ _____

Signature of Patient/Parent/Guardian *Date*