Janet A. Betchkal, M.D. P.A.

Practice Limited to Glaucoma & Related Eye Diseases -
wwwJanetBetchkalMD.com

HIPAA AUTHORIZATION AND CONSENT

HIPAA Notice of Privacy Practices Acknowledgment

I have had access to or received, read, and understand your Notice of Privacy Practices. I understand that this information will be used to carry outtreatment, payment, and normal healthcare operations of the Practice. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Authorization to Obtain and / or Release Medical and Pharmacy Records

I hereby authorize all physicians, health care entities, and pharmacies participating in my health care to obtain, release, use, and disclosure myentire medical record by mail, phone, fax, and electronic transmission in order to carry out my treatment, payment, and healthcare operations.

Lifetime Signature on File (Applies to Medicare patients)

I request that payment of authorized Medicare benefits be made on my behalf directly to Janet A. Betchkal, M.D. P.A., or professional associate for any services furnished to me by the practice. I authorize the release of any and all medical or other informationnecessary for processing claims to the Center for Medicare and Medicaid Services (CMS).

Authorization for Assignment of Insurance Benefits, Information Release, and Financial Responsibility

I authorize the payment of medical benefits be made on my behalf directly to the Practice for any services furnished to me by the physician or practice. I understand that I am financially responsible for any amount not covered by my insurance contract. I authorize the release to my insurance company any and all information concerning health care, advice, or treatment provided to me necessary for processing insurance claims. I understand if my insurance requires a prior authorization for office visits, procedures, inpatient or outpatient surgery, tests, or services, it is my responsibility to make sure the authorization is obtained prior to the visit, procedure, surgery, test, or service being performed. I understand that if I am seen withoutan authorization I will be considered a self- pay patient and will be required to pay in full for all services performed.

Authorization to Release Information to a Personal Representative or Third Party

Please complete the section below If you would like anyone else to have access to your information. I understand that authorization for release of information to the below can only be revoked upon written notice.

(*Check the type of information you authorize use to share.*)

Name	Relationship	Phone #	Power of Attorney	HIPAA Billing	HIPAA Medical
_____	_____	_____	☐	☐	☐
_____	_____	_____	☐	☐	☐

I acknowledge that all sections of this form have been read in full and explained as necessary.

Full Legal Name of Patient or Responsible Party _____

Signature Required: _____ **Date:** _____