MINNESOTA OPHTHALMIC
PLASTIC SURGERY SPECIALISTS
6405 France Avenue South Suite W460 | Edina, MN 55435

MEDICAL DISCLOSURE

Patient Name: _____ Date of Birth: _____/____/_____
Last First M.I.

Dear Patient,

In order to protect your privacy and to be in compliance with the new laws regarding patient privacy, we need your signature on this form in order to disclose medical information to any person other than yourself. If you do not sign this form, we will not divulge any medical information about you to anyone other than your insurance company. You can name your spouse, children, friend, "all family members" or anyone to whom you give permission to contact us about your treatment or surgery.

NAME	RELATIONSHIP TO YOU

SIGNATURE OF PATIENT: _____ Date: _____

Release of Medical Records:
If you are being treated by another doctor in a different clinic for the same condition, or if one of our doctors refers you to another doctor, please sign below if you would like us to send information to him/her regarding your treatment if he/she requests it. If you do not sign, the other office will need to obtain your signature before we can release any information.

SIGNATURE OF PATIENT: _____ Date: _____

Release of Photograph:
MN Ophthalmic Plastic Surgery Specialists does take photos for proof of medical necessity per your medical plan.
Please sign to authorize MN Ophthalmic Plastic Surgery Specialists to use any of your photos for the purpose and in such manner as may be deemed appropriate for ***teaching, publication, informational marketing, or research without publication of your name***.

SIGNATURE OF PATIENT: _____ Date: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT
I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can be and will be used to:

*Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
*Obtain payment from third-party payers.
*Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand this organization has the right to change its Notice of Privacy Practices from time to time and I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

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 healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

SIGNATURE OF PATIENT/or Caregiver: _____Date:_____

If Caregiver /relationship to patient: _____Date:_____