Hansen Vision Care
225 West Main Street
Rigby, Idaho 83442
208-745-8773

Acknowledgment of Privacy Notice

I authorize Hansen Vision Care to release and obtain all medical information requested by my health insurance carrier, Medicare or any other third-party payers. I authorize Hansen Vision Care to release or obtain all medical information to and from my referring physician or any other healthcare facility deemed necessary. I authorize Hansen Vision Care to contact my insurance company or health plan administrator and obtain or release all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company, health plan administrator, or health facility to release such information to Hansen Vision Care for reimbursement.

I understand that my signature acknowledges that I have had an opportunity to view and or receive a copy of the Providers Privacy Notice. It also acknowledges that I have given Hansen Vision Care my consent to release medical information or other information necessary to process my insurance claims and receive reimbursement from my health insurance. This serves as a signature on file in my medical chart for blocks 12 and 13 of the form HCFA-1500. Block 13 reads; I authorize payment of medical benefits to the undersigned physician of supplier for services described.

I agree that the provisions outlined in the privacy notice will remain in effect until I provide written revocation to Hansen Vision Care.

Patient Signature or Legal Guardian: ____

Relationship to Patient: Self____ Parent ____Legal Guardian____Other___________

Date: _________________