Pediatric Ophthalmology & Strabismus Associates

Patient Privacy Notice

We are required by Federal Law under HIPAA (Health Insurance Portability and Accountability Act) to notify you of our Patient Health Information Privacy Policy. A copy of the policy is available at our front desk, and also on our website. You may review it there at any time, or request a copy to take with you. We are also required to obtain your signature indicating that we have offered you a copy of our Policy.

By signing below, you are confirming that you understand that a copy of our Patient Health Information Privacy Policy is available any time upon request or on our website, www.posa-pa.com.

Patient Name_____

Signature _____
(Parent or Guardian signature if patient is a minor)

Relationship to Patient _____ Date_____

Authorization to Disclose Medical Information

It is the policy of our office to send a summary with the pertinent information to your/your child's primary care physician, or other physicians involved in your care, after each visit, or periodically for three reasons:

1. To document the visit for referrals which may be required by your insurance company
2. To keep your primary care physician updated as to the diagnosis and treatment of your eye condition
3. In response to consultation requests by your primary care physician or another physician who referred you to this office for consultation, second opinions or treatments

☐ I AGREE to the release of medical information to my/my child's primary care physician or other physicians involved in my/my child's medical care as outlined above.

☐ I DO NOT AGREE to the above release of medical information, with the exception of:

_____

Signature: _____

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