Bellipanni Eye Clinic

Matthew Bellipanni, OD
Chrissy Manning, OD
Walker Manning, OD

PATIENT MEDICAL INFORMATION RELEASE

I have been provided with a copy of the Health Insurance Portability and Accountability Act of 1966 (HIPAA). I understand and consent to Bellipanni Eye Clinic's use and disclosure of my protected health information for treatment, payment, and health care operations. I authorize Bellipanni Eye Clinic, or its authorized agents, to disclose general medical information and other protected health information (PHI) to the following persons and/or entities listed below. If no one is listed below, general medical information and other PHI will only be disclosed in those situations described in the Notice of Privacy Practices. This release will remain in effect until Bellipanni Eye Clinic is notified by me or in the case of a minor, at the time the patient turns 18 years old.

Person Or Entity Name	Relationship to Patient
1.	
2.	
3.	

Signature:

_____

Date:

_____