JENNIFER M. GUDAS, O.D., P.C.
"Complete Family Eye Care"
633 East 13th Street, P.O. Box 365
Winamac, IN 46996
Ph. (574) 946-3944 Fax (574) 946-6843

Patient Name_____

HIPAA Compliance Acknowledgement of Receipt

I acknowledge that I have received a copy of Jennifer M. Gudas, O.D., P.C. Notice of Privacy Practices.

Signed_____ Date_____

Authorization to Discuss Your Information with Family or Caregivers

To comply with the new HIPAA Federal Privacy Regulations, we must receive your written approval to discuss your case with anyone else, including your family, children, caregivers, etc. By authorizing this, we will be able to, without requiring your presence, discuss your case, answer questions, leave detailed messages, and contact the person(s) listed below in the event of an emergency. If you would like us to answer questions or discuss your case with anyone other than yourself, you must include them below. This authorization is optional and can be withdrawn at any time by you.

Name: _____ Ph.:_____
Relationship: _____
Name: _____ Ph.:_____
Relationship: _____
Name: _____ Ph.:_____
Relationship: _____
Name: _____ Ph.:_____
Relationship: _____

Authorization to File/Refile/Collect from Insurance

I authorize Dr. Gudas to release to my insurance carriers, including Medicare, any information required to file or resubmit my claim. I further authorize all Insurance companies, including Medicare Supplements, to pay Jennifer M. Gudas, O.D., P.C. directly on my behalf. I authorize all Insurance companies, Medicare, Medicaid, and Medicare Supplements to provide any information required to resubmit any denied or incorrectly paid claims. This authorization remains in effect until withdrawn by me.

Signed_____ Date_____