HIPAA - CLIENT INFORMATION

Victorious Images 7191 Richmond Road, Suite E Williamsburg, VA 23188.7239

NAME		DOB		
ADDRESS		CITY	ST	ZIP
HOME PHONE	CELL PHONE	WORK PHONE		EMPLOYER
INSURANCE NAME	SUBSCRIBER'S NAME	DOB		RELATION TO CLIENT
SECONDARY INSURANCE	SUBSCRIBER'S NAME	DOB		RELATION TO CLIENT
Email:				

HIPAA/Supplier Standards and Medicare Supplier Standards Acknowledgement

_____ I hereby acknowledge that I have been provided INFORMATION on where to locate Victorious Images' Notice of Privacy Practices and the Medicare Supplier Standards. (www.victoriousimages.com)

AUTHORIZATION TO DISCLOSE AND RECEIVE CLIENT HEALTH CARE INFORMATION

I hereby ***authorize*** permission to Victorious Images to RECEIVE any clinical and medical records needed from the Doctor(s) listed below and any other medical or professional establishment they deem necessary for the purpose of filing my insurance claims and to satisfy Medicare requirements.

Dr.(s) _____

Victorious Images may release any clinical information needed to my insurance carrier(s) listed above, to my referring Doctor(s), and to those listed below.

_____ _____

_____ _____

It is my understanding this authorization will remain in effect until I cancel by written notice.

_____ _____

Client Signature Date