AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION

I, _____(Patient name), authorize Eye Surgeons & Consultants, to release or discuss information related to my medical condition (including information related to my treatment plan, medication information and/or billing information) to the following named person(s)*

1. _____ Relationship: _____
2. _____ Relationship: _____
3. _____ Relationship: _____

*PLEASE BE ADVISED THAT ANY PERSON NOT REFERRED TO ON THIS LIST WILL NOT BE GIVEN ANY INFORMATION RELATED TO YOUR CASE, INCLUDING BILLING INFORMATION. YOU MAY CHANGE, RESTRICT OR EXPAND THIS LISTING AT ANY TIME.

*YOU ARE NOT REQUIRED TO LIST ANY NAME IF YOU DO NOT CHOOSE TO DO SO.

Please list any additional phone numbers where you would like us to contact you or leave a message for:

*Reminder notices

*Changes on scheduled appointments

1. _____

2. _____

Patient Signature_____

ACKNOWLEDGEMENT OF FEE

Form of payment for today's services:

Medical Insurance_____

Check One ( ) CASH ( ) CHECK ( ) CREDIT CARD_____ EXP_____

I understand there may be a separate Refraction Fee of $40 or Contact Lens Fee for your fitting, for which my insurance may not cover.

Patient name_____ Date_____

Signature_____

I understand there is an added fee for returned checks and collections accounts.