Medical Information Release Form
(HIPPA Release Form)

Name: _____ Date of Birth: _____/_____ /_____

Release of Information

( ) I authorize the release of information including the diagnosis, records: examination rendered to me and claims information. This information may be released to:

Please check one:

( ) Spouse _____

( ) Child(ren) _____

( ) Minor by _____

( ) Other _____

( ) Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call: ☐my home ☐my work ☐my cell number _____

If you are unable to reach me:
( ) You mage leave a detailed message

( ) Please leave a message asking me to return your call

( ) _____

The best time to reach me is (Day) _____ Between (Time) _____

Signed: _____ Date: _____/_____ /_____

INSURANCE ASSIGNMENT

Your signature is necessary for us to process any insurance claims and to ensure payment of services rendered.

Patient Name: _____ **Social Security Number:** _____

Non-Medical Patients:
I authorize the release of all medical information necessary to process any claim that is pertinent to my medical care. I assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, to The Eye Clinic. I authorize any holder of my medical information to release to my insurance provider(s) and its agents any information needed to determine benefits or the benefits payable for related services.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Non-Contractual Provider Disclosure:
If your insurance carrier is a non-contractual provider, The Eye Clinic will file for reimbursement for services rendered as stated in the Clinic's collection policy. However, having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on your contract with them, not with our office. It is your responsibility to pay the deductible, co-insurance, and any other balances not paid for by your insurance. We will assist you in receiving reimbursement as much as possible, but you are responsible for your bill.

Medicare Patients:
I request that payment of authorized Medicare benefits be made to me or on my behalf to The Eye Clinic for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits payable for related services.

I agree to be financially responsible for all charges relative to my provider plan. I have read this information and I understand it.

Responsible Party: _____

Witness: _____ **Date:** _____/_____ /_____

Revocation:
I hereby revoke all assignments made to The Eye Clinic as previously agreed to above.

Patient/ Guardian Signature: _____ **Date:** _____/_____ /_____

PATIENT ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Acknowledgement of Reading and Agreement
By signing this form below, I acknowledge that:

- I have received, read and understand you Notice of Privacy Practices containing a complete description of uses and disclosures of my Protected Health Information, or;
- I have read and understand the Notice of Privacy Practices, but I have chosen NOT to receive a copy of my own at this time.

Patient/ Guardian Signature: _____ **Date:** _____/_____ /_____