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**Release of Medical Information**

I have received a copy of Advanced Eyecare Associates Notice of Privacy Practices. I acknowledge that Advanced Eyecare Associates, the physicians, the technicians, and other Advanced Eyecare Associates staff may use and share my confidential health information with others in order to treat me, in order to arrange for payment of my bill and for issues that concern Advanced Eyecare Associates ’s operations and responsibilities.

Do we have your permission to:

 Discuss your medical condition with any family member or

 trusted friend?  Yes  No

If yes, whom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency Contact Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Release of Medical Information**

ASSIGNMENT OF BENEFITS: I voluntarily direct my insurance company (or Attorney at Law) to pay Advanced Eyecare Associates directly for charges for professional services rendered to me. THIS IS A DIRECT ASSIGNMENT OF BENEFITS UNDER THIS POLICY. I agree that I am responsible for any balance over and above insurance/attorney payment for these services.

CONSENT TO TREAT: I voluntarily authorize Advanced Eyecare Associates to administer examinations and care as deemed necessary for my condition.

AUTHORIZATION TO RELEASE RECORDS: I voluntarily authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in my case.

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Patient Name Printed

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Patient Signature Date