AUTHORIZATION and RELEASE

I authorize my insurance company to pay Eye Specialists insurance benefits that would otherwise be payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I also understand that I am responsible for all co-pays, deductibles, co-insurance and balances. I personally agree to pay for any and all services provided to me at the rates in effect during the time services are rendered. I understand and agree that my bill for services rendered is due and payable at the time of service and that I am ultimately responsible for any unpaid balances.

By signing this authorization, I agree that this office, and any third party used for treatment, billing, collection and other services, may use any means of communication with me, unless I say otherwise. Thus, I understand that any phone numbers and e-mail address provided by myself to Eye Specialists and to any of our service providers may leave messages for me manually and by using automated systems such as artificial or prerecorded voice. Specifically, if I provide a cellular phone number, I consent and agree to accept collection calls and other communications to my cellular phone from this office and from any of our service providers. I consent and agree that those calls may be automatically dialed, and that Eye Specialists and our service providers may use recorded messages. I also agree that Eye Specialists and any service providers may contact me by sending text messages and e-mails to any phone number or e-mail address that I provide to this office or service providers, and I consent to receive such text messages and e-mails which may identify the name of this office or service provider sending the communication, and which may disclose the nature of the communication.

Printed Name:_____

Signature of Responsible Party:_____ **Date:**_____

HIPAA Privacy Policy Acknowledgement of Receipt

I acknowledge that I was given the opportunity to receive a copy of Eye Specialists Notice of Privacy Practices.

Patient Name: _____

Signature:_____ **Date:**_____

Release of Records:

We will **not** disclose protected health information to anyone **(including a spouse)** unless you give us authorization to do so (only exception is parents of minor children). I authorize Eye Specialists to disclose my protected health information (PHI) to:

Name: Relationship:

- _____ Expiration date:___/___/_____
- _____ Expiration date:___/___/_____
- _____ Expiration date:___/___/_____
- _____ Expiration date:___/___/_____

*If no expiration date is given this authorization will automatically expire within 1 year from today's date

PHI to be authorized to disclose: ☐ Medical Record ☐ Health Record ☐ Entire Record