Authorization for Release of Previous Records and Identifying Health Information

INFORMATION IS REQUESTED FROM:

Practice/Doctor'sName:_____Date:_____

Mailing Address: _____

Phone: _____Fax:_____

Authorization for Release of Identifying Health Information

Patient Name: _____

Patient Address: _____
City Zip Code

Patient Phone: _____Patient DOB: _____

I authorize the professional office of my optometrist named above to release health information identifying me under the following terms and conditions:

- All records of previous eyecare
- The information will be released to Georgetown Eye Associates.
- At the request of the patient.

I have read and understand this form. I am signing it voluntarily. I authorize the disclosure of my health information as described above.

X_____ _____
Signature Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

_____ _____
Relationship to Patient Print Name

HIPPA Privacy Policy and Insurance Authorization

Georgetown Eye Associates works with both Medical insurance and Vision plans. If the reason for your exam is to update your glasses or contact lenses, and you are not having any other problems with your eyes, then the exam is considered a "routine" exam and is covered by your vision plan. Vision plans do not cover exams where medical issues are addressed. If you have a medical issue with your eyes such as allergies, dry eyes, diabetes, floaters, glaucoma, cataracts, macular degeneration, trauma, etc., your exam will be billed to your Medical insurance first, and then coordinated with your Vision plan if needed. Vision plans can be used toward the purchase of eyeglasses or contact lenses independent of where your exam is billed.

Medical Insurance:

Company: _____Policy/ID #_____

Group # _____Employer_____

Insured Member:_____Insured's Date of Birth:_____

Insured's Last 4 Digits of SS# _____

Patient Name:_____ Date of Birth:_____

I request that payment of authorized Medicare or any private insurance benefits be made on my behalf to Georgetown Eye Associates for services furnished to me. I authorize release of my medical information as needed to determine my benefits and pay my claims. I understand that I am financially responsible for all charges regardless of insurance coverage.

X_____ _____
Signature of Patient or Legal Guardian Date

HIPPA Acknowledgement:

I acknowledge that a copy of the Notice of Privacy Practices is available to me per my request.

X_____ _____
Signature of Patient or Legal Guardian Date