Authorization to Use and Disclose Protected Health Information

Patients Name:			
Current Address:	City:	State:	Zip:
Phone Number: ( ) -		Date of Birth:____/____/_____	
Name of Parent /Legal Guardian/POA:			

This authorization is to release protected health information to:

Name:	Relationship:
Phone: ( ) -	
Name:	Relationship:
Phone: ( ) -	

The purpose of this use or disclosure is to provide any requested information to the healthcare provider and/or others listed above. This information may also be used to add healthcare providers listed above to my medical record and send all future communications to this provider on my behalf. I acknowledge that I received a copy of Prairie EyeCare Center's notice of Privacy Practices. This authorization will expire in 24 months from the date signed. Requests to add a healthcare provider and to share medical information do not expire unless a written request to revoke this authorization is received by Prairie EyeCare Center, PC.

Please read and initial: In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. All professional services and materials are charged to the patient. The undersigned will ultimately be responsible for any bill incurred at this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks. _____

I understand that my vision and/or medical insurance can be billed when applicable and that payment is made directly to Prairie Eyecare Center, PC. If I pay for services on the date they are rendered and receive a discount for doing so, I waive my right to have the insurance claim filed at a later date. I understand that all benefits quoted to me are not a guarantee of payment by my vision or medical insurance provider. _____

I hereby authorize the release of any information necessary to process my insurance claims. I authorize payment directly to Prairie Eyecare Center, PC for any professional services rendered to my dependent or me. I further understand that I am financially responsible for any charges not paid by my insurance company, unless my insurance plan is one that contracts directly with Prairie Eyecare Center, PC and they determine that I am not responsible. Regulations pertaining to medical assignment of benefits apply. In the event it becomes necessary to collect the amount due on my account by legal litigation, the handling fees, service charges or court costs will be paid by the guarantor. _____

Signature: _____ Date: _____

Parent/Legal Guardian/POA Signature: _____

Relationship to Patient: _____