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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

By signing this form you acknowledge that you have received a copy and are aware of our Notice of Privacy Practices, effective September 23, 2013. You may request a new copy at any time.

Please read the statements below. By checking each individual box, you are giving our office the authorization to release your medical information.

- □ **Medical benefits to the physician or supplier.** By checking this box, you are allowing your insurance company to pay us for your office visit.
- □ **Medical information necessary to process this claim and all future claims.** By checking this box, you are allowing us to send your insurance company any information needed in order to process your claim.
- □ **Medical claims to be submitted electronically if your insurance company requires it.**
- □ **Your Pharmacy**. By checking this box you are allowing us to call in any prescription and/or refills on any of your eye medication(s).
- □ **Optician**. By checking this box, you are allowing us to give your eyeglass prescription to the optician of your choice.
- □ **Contact Lens Company**. By checking this box you are allowing us to give your contact lens prescription to the optician or contact lens company of your choice.
- □ Any other physician that requires information about you, such as your Primary Care Physician or any other Specialist.

X:_____ Date:_____
Signature

Please give us the name of a person that you would authorize us to release confidential information to, such as test results, billing questions or treatment.

Name:_____Relationship:_____Phone Number:_____