 **AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION**

I understand that payment in full is due at time of service unless other arrangements are made. Filing an insurance claim does not guarantee benefits or payment. Please check with your insurance provider to verify your eligibility. I understand that I am financially responsible for all charges whether or not paid by insurance.

I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners.

I authorize the release of any information including the financial details, the diagnosis, and the records of any treatment or examinations rendered to me or my child to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient or parent (if minor) Date

**HIPAA** **Privacy Practice Acknowledgement**

⃝ I have received a copy of the Jensen Eyecare Center Notice of Privacy Practices

**OR**

⃝ I was offered but decline a copy of the Jensen Eyecare Center Notice of Privacy Practices.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_

Printed Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_