HIPAA, Disclosures & Consents

Please initial each line and sign at the bottom

_____**Medicare/Other Insurance Authorization:** I authorize that Medicare/Other Insurance benefits be made on my behalf to Rockwall Eye Associates and its Affiliates for services provided. I authorize release of medical information necessary to process the claim. I understand that I am financially responsible for charges and guarantee payment of all charges incurred during treatment, consistent with the terms of my insurance policy.

_____ **Medication Profile:** I authorize Rockwall Eye Associates to access my medication profile necessary for medical evaluation and treatment.

_____ **HIPAA:** I have had the opportunity to review the "Notice of Privacy Practices" that explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ **Communication:** I authorize Rockwall Eye Associates and its representatives to mail, call, or e-mail me regarding my healthcare. This authorization may be rescinded at any time by notifying the office in writing. I understand that the office will not disclose health care information, except as permitted by law, without my prior written consent.

_____ **Form expenses:** If you or an unrelated third party acting on your behalf requires us to complete forms (disability forms, FMLA forms, pharmacy pre-authorizations, etc.), there will be a charge of $25 to cover the expense involved.

I authorize you to discuss my medical record and release any and all medical information to the following individuals:

_____ No one other than myself

_____ My Spouse _____ Phone: _____

_____ My Parent _____ Phone: _____

_____ Other _____ Phone: _____

_____ _____

Signature of Patient or Representative Date

_____

Printed Name

_____

Witness