

# Meridian Family Eyecare

## DISCLOSURE OF PROTECTED HEALTH INFORMATION

I acknowledge that I have received a copy of Meridian Family Eyecare’s notice of Privacy Practices.

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

I hereby authorize the following people to be made aware of my test results, appointment times, medical information and patient account status. I understand that if someone inquires about any of the information listed above and is NOT listed on this consent form, information will NOT be released. We must have a signature authorizing release of any medical information.

\_\_\_\_\_  
NAME/RELATIONSHIP TO PATIENT

\_\_\_\_\_  
NAME/RELATIONSHIP TO PATIENT

\_\_\_\_\_  
NAME/RELATIONSHIP TO PATIENT

\_\_\_\_\_  
NAME/RELATIONSHIP TO PATIENT

\_\_\_\_\_  
NAME/RELATIONSHIP TO PATIENT

\_\_\_\_\_  
NAME/RELATIONSHIP TO PATIENT

## AUTHORIZATION

I authorize Meridian Family Eyecare to release any medical information pertaining to my care to my referring physician, any physician I am referred to from this office, and any other physician/office participating in my care. I authorize treatment from this office and payment of medical benefits to the physician/supplier for those services rendered not to exceed the total billed charges for those services. I authorize the release of any information necessary to process insurance claims and I certify the information contained herein is correct. I permit a copy of this authorization to be used in place of the original. Regulations pertaining to medical assignment of benefits apply.

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PATIENT’S NAME(PLEASE PRINT)

## FOR OUR MEDICARE PATIENTS

After you are seen by the doctor, Meridian Family Eyecare will submit a completed insurance form to Medicare. Their guidelines permit us to obtain a one-time signature that is valid for this and future visits to our office. By signing below, the notation “SIGNATURE ON FILE” will appear *in lieu* of your signature on all Medicare forms submitted for you by our office.

X \_\_\_\_\_  
Signature of Medicare Beneficiary