# 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 may 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

**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 NAME (PLEASE PRINT)

For Office Use Only

Complete this section if this form is not signed and dated by the patient or an authorized representative of the patient.

I have made a good faith effort to obtain a written acknowledgement of receipt of the notice of Privacy Practices for Meridian Family Eyecare, but was unable to do so for the following reasons:

☐ Patient or authorized representative refuses to sign

☐ Patient is unable to sign

☐ Other: _____

Employee Name _____ Employee Signature _____ Date _____