Fishbaugh Family Eyecare

Patient Name_____ **Date of Birth**_____

Email _____ **Social Security Number** _____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

- I understand as a recipient of care by Fishbaugh Family Eyecare, my medical and health information will be shared as permitted by law. I understand I can revoke this consent in writing; any alteration can only apply to future disclosures and cannot cancel actions taken or disclosures made while the designation was in effect.

- I authorize Fishbaugh Family Eyecare to use and disclose information as necessary for my treatment and payment purposes.

Medical Information Release

We must have your consent to discuss your medical care with someone other than yourself including spouse or other family members. This authorization allows a patient to designate family members, friends or other individuals to whom the practice may release Protected Health Information.

Name	Relationship	Telephone Number
Name	Relationship	Telephone Number
Name	Relationship	Telephone Number

In order for Fishbaugh Family Eyecare to better communicate with your doctors please list their information below.

Primary Care Doctor:
Name of Provider, Facility or Person: _____
Address: _____
Phone:_____ Fax: _____

☐ Yes I would like my health information to be communicated or discussed with my primary care doctor (this includes diabetic eye reports that doctors request).
☐ No I would not like my health information to be communicated or discussed with my primary care doctor.

Specialist Doctor:
Name of Provider, Facility or Person: _____
Address: _____
Phone:_____ Fax: _____

☐ Yes I would like my health information to be communicated or discussed with my specialist care doctor (this includes diabetic eye reports that doctors request).
☐ No I would not like my health information to be communicated or discussed with my specialist care doctor.

Fishbaugh Family Eyecare

Specialist Doctor:
Name of Provider, Facility or Person: _____
Address: _____
Phone: _____ Fax: _____

☐ Yes I would like my health information to be communicated or discussed with my specialist care doctor (this includes diabetic eye reports that doctors request).

☐ No I would not like my health information to be communicated or discussed with my specialist care doctor.

Health Information Exchange

We participate in one or more Health Information Exchanges. Your healthcare providers can use this electronic network to securely provide access to your health records for a better picture of your health needs. We, and other healthcare providers, may allow access to your health information through the Health Information Exchange for treatment, payment or other healthcare operations. This is a voluntary agreement. You may opt-out at any time by notifying Fishbaugh Family Eyecare.

☐ Opt-In ☐ Opt-Out

Acknowledgement of Responsibility

I acknowledge that I am personally responsible for this account. I authorize my insurance to pay directly to the provider. Even though Fishbaugh Family Eyecare may file and verify eligibility, this is not a guarantee of payment by the insurance company for any services. I assume full responsibility for any non-covered services, co-payments or deductibles that my insurance company does not pay, and that it is my full responsibility to inform Fishbaugh Family Eyecare of any insurance changes. I also understand there will be a $30 charge for any missed or canceled appointment with less than 24 hour notice. If three appointments are missed or cancelled within one year, treatment will be declined.

Patient Financial Responsibility (if other than self)

Parent/Guardian _____ Date of Birth _____ Social Security Number _____

Address _____ City _____ State _____ Zip Code _____

Telephone Number _____ Alternate Telephone Number _____ Place of Employment _____

I acknowledge that I was offered a copy of the Notice of Privacy Practices.

Signature of Patient or Authorized Representative _____ Date _____

Relationship if authorized representative _____