DO WE HAVE YOUR PERMISSION TO:

Leave a message on your home answering machine/voice mail/family member? YES NO

Leave a message at your place of employment? YES NO

Discuss your medical condition(s) with a family member/
member of your household/friend/other? YES NO
if yes, Whom:______________________ Relation:______________________

Discuss your medical billing or insurance information with a family member/
member of your household/friend/other? YES NO
If yes, Whom:______________________ Relation:______________________

Any other restrictions or authorizations? YES NO

Please explain ____

____

I hereby authorize the processing of the medical insurance either by electronic or manual method by White Eye Associates. My signature authorizes payment of all major medical and /or surgical benefits to which I am entitled from the listed insurer to pay to White Eye Associates. I further authorize asignee to release all medical and/or insurance claim information necessary to secure the payment(s). I recognize my financial obligation of any co-insurance or deductible and non-covered services that may be required. This agreement will remain in effect until revoked by me in writing. A photocopy of this document is to be considered as valid as an original.

HIPAA: I hereby give my consent for White Eye Associates to use and disclose Protected Health Information (PHI) about me to carry out treatment, payment and healthcare operations.
I have received and read the **NOTICE OF PRIVACY PRACTICES** prior to signing this consent.

____ ____
Signature of Patient or Representative Date

____
Print Name

____
Relationship of Representative to Patient

Please describe the Representative's authority to act on behalf of Patient: ______________________

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