Zieker Eye Ophthalmology PC

Name	
SSN	
DOB	
Address	
Phone	
Email	
Primary Care	
Emergency Contact	Name Relation Phone

Authorization for Release of Protected Health Information

I authorize Zieker Eye Ophthalmology PC to release protected health information to:

Voicemail	YES	NO	Other(s) Listed Here:
Spouse	YES	NO	_____
Parents	YES	NO	_____
Children	YES	NO	_____

Acknowledgement and Consent

I acknowledge that I have had the opportunity to read through the following forms and I consent to all terms. I understand the terms may change with time, and that current terms and copies of those terms are available upon request. I acknowledge that I have had the opportunity to read the Financial Agreement and understand that I am responsible for any copay, co-insurance, deductible and/or non-covered service. I understand that interest will be added to my account for all statements past 60 days and that any balance unpaid at 60 days will be turned over to a collections attorney/agency. I acknowledge that I have read the Refraction Policy and understand that most insurances do not cover the refraction. I accept full financial responsibility for the $32 fee for this service. The copay, co-insurance, and deductible are separate from, and not included in, the refraction fee. I understand that I am responsible for this fee if I do not decline this service before it is performed. I acknowledge that I have had the opportunity to read the Consent to Use or Disclose Protected Health Information for Treatment, Payment and Health Care Operation and the Notice of Health Information Practices Summary. I consent to allow Zieker Eye Ophthalmology PC to use or disclose my protected health information for treatment, payment and health care operations. I acknowledge that this Authorization for Release of Medical Information allows Zieker Eye Ophthalmology PC to share information with parties specified until revoked in writing. I may cancel authorization of the above parties by submitting a written request to Zieker Eye Ophthalmology PC, except where a disclosure has already been made in reliance on my prior authorization(s). If the person or facility receiving this information is not covered by privacy regulations, the information could be redisclosed. This authorization includes release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information. I hereby release Zieker Eye Ophthalmology PC and its staff and affiliates from all responsibility for any loss or damage to personal property. I authorize and give my consent to the staff of Zieker Eye Ophthalmology PC for such examination(s), therapy(ies), treatment(s), test(s), or procedure(s), to be performed upon me as, in their judgement, are necessary or advisable to my diagnosis, treatment or care. I understand that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees or assurances have been made to me as to the results or effects of any examination(s), therapy(ies), treatment(s), test(s), or procedure(s). I understand it is my responsibility to inform Zieker Eye Ophthalmology PC of any change in medical health or status.

Signature _____ **Date**

Print Name _____ **Relation**_____