RETINA ASSOCIATES
Experts in Medical & Surgical Eyecare

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PATIENT CONSENT and AUTHORIZATION
For Use and Disclosure of Health Information/ Assignment of Benefits/Financial Agreement

Patient Name: _____ **DOB:**_____
The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I give my consent for Retina Associates to discuss my health condition and provide all health information about me to:

Spouse: Name_____ Phone #_____

Child: Name_____ Phone #_____

Parent: Name_____ Phone #_____

Other: Name_____ Phone #_____

Other: Name_____ Phone #_____

By signing this form, you authorize Retina Associates to use and disclose protected health information about you as outlined above. You have the right to revoke this authorization at any time, in writing, signed by you. Such revocation shall not affect any disclosures we have already made in reliance on your prior authorization.

Patient Signature: _____ **Date:** _____

If the patient is a minor or unable to sign please complete the following:

☐ Patient is a minor: _____ years of age ☐ Patient is unable to sign because: _____

Print Name of Authorized Representative: _____

Authority of representative to sign on behalf of the patient:
☐ Parent ☐ Legal Guardian ☐ Court Order ☐ Other: _____

Authorized Representative: _____ **Date:** _____

ASSIGNMENT OF BENEFITS/FINANCIAL AGREEMENT

I request that payment of medical insurance benefits be made directly to Retina Associates for services furnished to me by them. I authorize release of medical information about me to determine these benefits.

I have read the Financial Policy and agree to its provisions.

Patient Signature _____**Date:** _____