# HIPAA Release of Information and Acknowledgements

Name: _____ Date of Birth: _____/_____/_____
(Please Print)

By signing this authorization, I authorize The Eye Center to release/disclose my medical information, medical history, progress notes with diagnosis, laboratory data, imaging studies and claims information. This information may be released to:

[ ] My Spouse/Partner: (name) _____

[ ] My Child(ren): (names) _____

[ ] Other: (name )_____

[ ] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing. My written revocation must be submitted to The Eye Center, 120 Medical Blvd Ste 101, Spring Hill, FL 34609.

I do not have to sign this authorization in order to receive treatment from The Eye Center. I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

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**Authorization To Release Medical Information.** I authorize the release of my information to my insurance company and the assignment of benefits from my insurance company to The Eye Center.

**Patient responsibility for Payments:** In being accepted as a patient of The Eye Center I realize that I am responsible for all charges incurred. Payment for services is due the day services are provided. I understand The Eye Center will file my insurance for me, but I am responsible for deductibles, co-payments, uncovered services and claims denied by my insurance company. I understand that if I am sent to collections for unpaid balances, I will be charged a $25.00 collection fee for processing the account.

**Receipt of Notice of Privacy Practices**: I acknowledge that I have received or have been given the opportunity to receive a copy of the Notice of Privacy Practices that describes how my health information is used and shared. I understand that The Eye Center has the right to change this notice at any time. I may obtain a current copy by contacting The Eye Center.

**Consent to Dilation**: It may be necessary to dilate your eyes during your eye examination or treatment. Dilation results in sensitivity to light and an inability to see well at close range or distance for a few hours. Patients should wear sunglasses, be cautious walking and going up or down stairs. We recommend not driving or operating dangerous machinery immediately after dilation. We recommend that someone drive you home or that you wait until your eyes return to normal so that you can drive safely.

Signed By: _____ Date: _____/_____/_____
Signature of Patient or Legal Guardian