# Garland Eye Associates, P.A.

## Medical Information Release Form (HIPAA)

Patient Name: _____ Account #_____

Date of Birth: _____

## RELEASE OF INFORMATION

I authorize the release of information including records, diagnosis, examination rendered to me and financial information. This information may be released to:

- ☐ Spouse Name & Phone #_____
- ☐ Child(ren) Name & Phone #_____
- ☐ Other Name & Phone #_____
- ☐ Information is not to be released to anyone

## Messages

If unable to reach me:

- ☐ You may leave a detailed message.
- ☐ Please leave a message asking me to return your call.
- ☐ Other instructions: _____

This **Release of Information** will remain in effect until terminated by me in writing.

_____ _____

Patient Signature Date

## REFRACTION POLICY

Refraction is the process of determining the eye's refractive error, or the need for eyeglasses. It is a separate part of the eye exam and is NOT a covered service by Medicare or most insurance plans. Our office fee for the refraction is $40.00. This fee is collected in addition to the patient's copay, deductible or coinsurance.

ACKNOWLEDGEMENT:

I have read the above and understand that the refraction is considered a non-covered service by most insurance plans. I accept full financial responsibility for the cost of this service.

_____ _____

Patient signature (Parent for Minor) Date