Columbia Eye

Columbia Eye
Surgery Center

CONSENT AND AUTHORIZATION

Consent For Treatment:

I hereby agree and give consent to the treating physician and employees of Columbia Eye Clinic, PA/Columbia Eye Surgery Center, Inc. and other associates to diagnose and treat the patient named on this form. I consent to any and all treatment including, but not limited to, physical examinations and other procedures related to the routine diagnosis and treatment of the patient as determined necessary and appropriate by the treating physician, his/her partner, associates, and consultants.

Authorization/Release:

I hereby authorize and request the payment of services from Medicare, Medicaid and/or other insurance plans or payers be made on my behalf to Columbia Eye Clinic, P.A./Columbia Eye Surgery Center, Inc. I hereby assign to Columbia Eye Clinic, PA/Columbia Eye Surgery Center, Inc. all payments for treatment services. I understand and agree that I am responsible for paying any amount not covered by Medicare, Medicaid, and/or other insurance plans or payers.

I hereby acknowledge receipt of the NOTICE OF PRIVACY PRACTICE and understand my rights contained in the notice. I hereby authorize the release of medical information to Medicare, Medicaid and/or other insurance plans or payers. I also authorize the release of medical information to other healthcare providers including, but not limited to, my primary care or family physician, consulting physicians or healthcare providers, hospitals, rehabilitation centers, or other healthcare providers or facilities. I permit a copy of this authorization to be used.

HIPAA Verbal Release Authorization:

I authorize the verbal release of information including the diagnosis, treatment, testing, examination findings, and claims information from Columbia Eye, P.A. & Columbia Eye Surgery Center, Inc. to the following person(s):

Name/Relationship	**Name/Relationship**

Patient's Name (PRINTED)	***Patient's Date of Birth***
Patient's Signature	***Date***

Signature and Relationship if NOT Patient (ex: Parent, Child, Caregiver)