Privacy and Insurance Authorization

HIPAA AUTHORIZATION

I: FOR USE OR DISCLOSURE OF HEALTH INFORMATION Our Notice of Privacy Practices provides information about how Dr. Neill S. Cowles may use and disclose your protected health information and when we need your written authorization to do so. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards. Name of Patient (print):

The purpose of this authorization is: 1: Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. 2: Obtain payment from 3rd party payers. 3: Conduct normal health care operations.

My Rights I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. I have read, received, and understand the Notice of Privacy Statement.

Insurance Authorization

II. I authorize release of any medical information necessary to process any insurance claims, and I authorize payment of medical benefits directly to the physician or supplier of services for myself and/or dependents. I understand I am responsible for any deductibles, co-insurances or fees for services not covered by the insurance carrier. I accept there may be fees that occur with missed appointments and cancellations without 24 notices.

III: Dilating drops may be instilled in your eyes during your examination. These drops may blur your distance vision and will most likely blur your reading vision for a few hours. You will also be light sensitive.

Signature_____

Printed Name: _____

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 Representative: _____

Relationship to Patient_____

Signature: _____Date: _____