INSURANCE ASSIGNMENT, CONSENT, RELEASE AND REQUEST OF MEDICAL RECORDS AND NOTICE OF PRIVACY

ASSIGNMENT OF INSURANCE BENEFITS

Patients with insurance (vision or medical) please read and sign below. I hereby assign all benefits to which I am entitled thru private medical insurance and any other vision plans to New Albany Vision Clinic. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize New Albany Vision clinic to release all information necessary to secure payment.

Signature____Date:_______________________

CONSENT FOR TREATMENT

The undersigned hereby consents to treatment, including examination and procedures that are deemed necessary, including dilation, for appropriate diagnosis, by New Albany Vision Clinic.

Signature____Date:_______________________

NOTICE OF RECEIPT OF HIPAA PRIVACY PRACTICES

I hereby certify that I have reviewed a copy of the HIPAA Privacy Practices for New Albany Vision Clinic. (Please tell us if you would like a copy for your personal records).

Signature____Date:_______________________

AUTHORIZATION TO REQUEST AND RELEASE MEDICAL RECORDS AND INFORMATION

This authorizes you to release to New Albany Vision Clinic, located at 484 W Bankhead Street, New Albany, MS 38652, their agents or representatives, full and complete medical records, evaluations, consultations or information (hereinafter collectively referred to as "medical records") you may have in custody concerning the undersigned patient. The undersigned represents and warrants that he/she has full authority to request said records and to agree to all the conditions recited herein.

This also authorizes New Albany Vision Clinic to release said "medical records" described above to any physician's office in which you have been referred or is involved in any treatment or care of the undersigned.

The undersigned expressly releases and forever discharges and agrees to identify and hold harmless New Albany Vision Clinic, its directors, officers, agents, employees, successors and assigns from any and all claims, damages, actions, causes of action or suits of any kind or nature whatsoever arising of, or from, the release or receipt of any medical records pursuant to this authorization.

Signature____Date:________________________