# PATIENT CONSENT FORM

1) I authorize the office of Family Eye Care Rock Valley to act as my agent in helping me obtain payment for my insurance benefits. I authorize payments of these benefits directly to Family Eye Care Rock Valley on my behalf, for any services or materials furnished. I authorize Family Eye Care Rock Valley to release my information needed to determine these benefits payable for related services.

2) I authorize Family Eye Care Rock Valley to release any medical information which is needed to determine medical treatment. Any related information can be transferred via paper, orally, or electronically.

Patient Signature: X____________________________________________ Date: ____________________

# ACKNOWLEDGEMENT

I acknowledge that on __________ day of ________________, 20_____, I was presented with the opportunity to read Family Eye Care Rock Valley's Notice of Privacy Practices in compliance with HIPAA.

Patient Signature: X____________________________________________ Date: ____________________

Or: X ________________________________________________

Guardian or Representative