

PATIENT'S NAME _____ DOB _____

IF MINOR, PARENT OR GUARDIAN'S NAME _____

**Authorization of Treatment,
Insurance Release Form and Notice of Privacy Act**

Authorization of Treatment

While I am here I permit the employees, the healthcare provider, and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand the attending healthcare provider will explain to me the nature of my condition and his/her recommended treatment and any associated risk involved. I also understand that they will explain to me other ways this condition could be treated. I further understand that this care may include diagnostic testing, examination, medical and/or surgical treatment and no guarantees have been made to me about the outcome of this care.

Medicare/Medicaid Lifetime Consent

I certify that the information given me in applying under Title XVII of the Social Security Act is correct. I authorize any holder of medical and/or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare Claim. I request that payment of authorized benefits be made on my behalf. I authorize payment for medical benefits to be made directly to the healthcare provider or Harmon Vision Center.

All Other Insurance

Authorization is hereby granted Harmon Vision Center to release medical records and such information as may be requested for the completion of my claim to my insurance company. I further authorize payment for medical or vision benefits to be made directly to the health care provider or Harmon Vision Center. **I understand that I am personally responsible for Services provided by Harmon Vision Center.**

Notice of Privacy Act

I acknowledge that I received a copy of Harmon Vision Center's Notice of Privacy Practices.

Signature _____ Date _____