



Eye Care for the Adirondacks
Malone-Office

75th Sixth Street, PO Box 604, Malone, NY 12953 Office Phone 518.483.0065 Office Fax 518.483.0809

**Authorization for Payment of Insurance Benefits
And Release of Information From
Eye Care *for the* Adirondacks**

I request that payment of authorized Medicare and/or my insurance benefits be made on behalf of Eye Care *for the* Adirondacks for any services furnished to me by any physician or provider of that professional organization. I authorize Eye Care *for the* Adirondacks to release medical information about me as necessary to the Health Care Financing Administration and/or my insurance carrier in order to determine these benefits or benefits payable for related services.

I understand that I am financially responsible for any balances my insurance carrier does not pay.

If insurance is not involved, I agree to pay at the time of service unless other arrangements have been made.

Signature of Patient: _____ **Date:** _____

Witness: _____ Date: _____

I give permission for Eye Care *for the* Adirondacks to communicate any, all, or a summary of findings pertinent to the overall management of my health to:

My Primary Care Provider: _____

And Secondary Provider, Specialist, School, or other: _____

