Eye Care for the Adirondacks
450 Margaret Street Plattsburgh, NY 12901 Phone (518) 566-2020 Fax (518) 566-8211

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: _____

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Print Form