PATIENT CONSENT FORM

Patient Name ______________________________ Date of Birth________________________

I, __________________________________, HEREBY GRANT CONSENT TO the Highland Vision Clinic to release my medical my records to my medical or insurance plan (such as VSP) for the purpose of reimbursement, or to share such information as is necessary for my ongoing care and the health care operations of this office.

PLEASE READ CAREFULLY:

I understand that my medical records are confidential. I understand that by signing this consent form, I am allowing my medical information to be released upon my insurance company's request, for the purpose of Health Care Operations (including, but not limited to, provider review functions, claims payment and quality assessment.) I also understand that I may revoke this consent by written request, at any time, with this doctor or clinic. If revoked, it is understood by all parties that all information released prior to being notified of such revocation was made with my consent.

For additional information on our Privacy Policy, please refer to our office handbook or your insurance company's website. We reserve the right to update our policy periodically and make changes as required.

I understand that I have the right to restrict the disclosure of specific information in my medical records if I request such restriction in writing, and that my request may be denied if the information restricted is required for Health Care Operations.

Insurance benefit information provided by Highland Vision Clinic is not a guarantee of payment by my insurance carrier; I agree to pay all charges not covered by my insurance.

I have read the above and foregoing consent for release of information. I do hereby acknowledge that I am familiar with and fully understand the terms and conditions of the consent.

Signature ______________________________ Date ______________________________