



EYE SPECIALISTS

● 1103 Galvin Road South, Suite H Bellevue, NE 68005 PH: 402-292-6514 ● 9910 S 71st Plaza, Suite 103 Papillion, NE 68133 PH: 402-933-0708

Release of Information

We will **NOT** disclose protected health information to anyone **(including a spouse)** unless you give us authorization to do so **(only exception is parents of a minor child)** . I authorize Eye Specialists to disclose my protected health information (PHI) to:

Name/Relationship: _____ Expiration: _____

Name/Relationship: _____ Expiration: _____

Name/Relationship: _____ Expiration: _____

**This authorization will automatically remain in force indefinitely, if no expiration date is given.

PHI to be authorized to disclose: Medical/Health Records Billing/Insurance Information Entire Record

Policy Notice Receipt of Acknowledgement (INITIAL EACH)

_____ I acknowledge that I was offered a copy of the **Notice of Privacy Practices**.
Initial

_____ I acknowledge that I was offered a copy and agree with the terms of the **Financial Policy**.
Initial

Signature of Patient or Responsible Party _____ Date _____

Work Comp/Accident Information (if applicable)

Employer Name _____

Address _____

City State Zip

Employer Phone _____ Employer Fax _____

HR Representative _____ Phone _____

Work Comp Insurance Company

Address _____

City State Zip

Phone _____ Fax _____ Claim # _____

Claim Adjustor _____ Phone _____ Fax _____

Case Manager _____ Phone _____ Fax _____

* Has this been reported to the employer? YES NO

Signature of Patient or Responsible Party _____ Date _____