



Craig W. Baier, O.D.

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Patient Name: _____ DOB: _____

Address: _____ City _____ Zip _____

Phone : (H) _____ (C) : _____

SS# _____ Employer & phone: _____

Email _____ (if provided, you consent to receiving emails from our office)

Emergency contact person & phone: _____

1. I authorize my optometrist to discuss or release billing/insurance information and health information (including glasses and contact lens prescriptions, medication prescriptions, medications and all exam findings) identifying me to the following individuals:

Name and relationship

Name and relationship

Name and relationship

Name and relationship

2. This authorization is being made voluntarily by me and at my request.

3. In signing this authorization, I understand and acknowledge the following (initial in the space provided):

_____ I understand this authorization is voluntary and that I may refuse to sign it.

_____ I understand that my refusal to sign this authorization will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law.

_____ I understand that I may revoke this authorization at any time by notifying my optometrist in writing of my intent to revoke this authorization, except to the extent that action has been taken in reliance to this authorization.

_____ I understand that once the disclosures authorized herein have been made, the information disclosed may be subject to re-disclosure by any recipient and no longer protected by federal privacy law.

I do hereby swear that I have read and understand the above information.

Date

Signature of Patient/Legal Representative

Printed Name of Legal Representative

Relationship of Legal Representative to Patient

Website