VISION DESIGN
optometry

INSURANCE PATIENT'S CONSENT FORM

Patient Name:_____

Date of Birth:_____

I authorize **VISION DESIGN OPTOMETRY** to release medical records for the above specified individual to the respective insurance company (ies).

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 release upon my insurance company's request, to my insurance company for the purpose of Health Care Operations (including, but not limited to, provider review functions, claims payment and quality assessment).

I understand that I may revoke this consent by written request at any time, with this office. 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 the insurance company's confidentiality policy, please contact the insurance company directly. Each insurance company updates their patient confidentiality policy periodically and reserves the right to 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. I also understand that my request for restriction may be denied if the information restricted is required for Health Care Operations.

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: _____ ☐ Self ☐ Parent/Guardian

Date:_____

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