Craig W. Baier, O.D.

515 N. Main, Newton, KS 67114 office (316)283-2112 fax (316)283-0600

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