Eye Associates
OF BUCKS COUNTY

Patient Name: _____
Date of Birth: _____

www.eabceyes.com

**PATIENT CONSENT AND DISCLOSURE AUTHORIZATION**
Revised September 2013

- By signing this PATIENT CONSENT AND DISCLOSURE AUTHORIZATION, the patient or legal guardian of a minor patient understands and acknowledges that Eye Associates of Bucks County, a Division of Vantage EyeCare LLC, is committed to securing the privacy of health information. Accordingly, we have posted our **Notice of Privacy Practices** in our offices and the patient has been provided the opportunity to take a copy.
- The HIPAA Privacy Rule gives the individual the right to request the release of Protected Health Information (PHI) to identified individuals.
- I authorize my PHI to be disclosed to the following individuals only:

  Name: _____ Relationship: _____

  Name: _____ Relationship: _____

  Name: _____ Relationship: _____

**Lifetime Signature on File and Assignment of Benefits:**

I request that payment of any and all authorized insurance benefits be made on my behalf to Eye Associates of Bucks County, a Division of Vantage EyeCare LLC for professional services rendered. I authorize Eye Associates of Bucks County, a Division of Vantage EyeCare LLC to release information about me to any private insurance carrier and/or to the Centers for Medicare and Medicaid Services (CMS) required to determine these benefits or the benefits payable for related services. I understand that I am financially responsible for any amount not covered by insurance or any amount deemed the subscriber's responsibility as defined by my insurance company, including copays, coinsurance, deductibles, and non-covered services.

| _____ | _____ | _____ |
|---|---|---|
| Print Name | Signature | Date |

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