

# EYE CARE FOR TULSA, INC

## Release of Information to Insurance

I agree to the release of *Charges, History, Diagnosis, Treatment and Recommendations* from my medical records to Medicare and/or my private insurance carrier, if needed, to process claims for payment. Oklahoma Statute Title 63 §1-502.2 requires that we advise: "The information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease."

\_\_\_\_\_  
Patient's (or parent/legal guardian's) Signature

\_\_\_\_\_  
Today's Date

## Release of Information to Individuals

I authorize the release of any information including the diagnosis and the records of any treatment or examinations rendered to me to the following individual(s):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

\_\_\_\_\_  
Patient's (or parent/legal guardian's) Signature

\_\_\_\_\_  
Today's Date

## Receipt of Notice of Privacy Practices

I have received or been offered a copy of Eye Care for Tulsa's Notice of Privacy Practices.

\_\_\_\_\_  
Patient's (or parent/legal guardian's) Signature

\_\_\_\_\_  
Today's Date

## Receipt of Financial Policy

I have received or been offered a copy of Eye Care for Tulsa's Financial Policy.

\_\_\_\_\_  
Patient's (or parent/legal guardian's) Signature

\_\_\_\_\_  
Today's Date