



Information Release/Emergency Contact

I authorize Retina Associates of Cleveland, Inc to release to the individual(s) listed below information regarding my care, including office visits, medical information, testing, and billing.

Name Relationship Phone Number

Name Relationship Phone Number

X _____
Patient Signature Witness Date

Authorization to Release Information and to Pay Benefits

I hereby authorize Retina Associates of Cleveland, Inc and/or its employees or agents to release any information acquired in the course of my examination or treatment to my insurance company or companies for claims processing.

I hereby authorize payment directly to Retina Associates of Cleveland, Inc for all medical and/or surgical services, if any, otherwise payable to me for services provided by one or more physicians and/or agents of Retina Associates of Cleveland, Inc.

X _____
Patient Signature Date

I have received the notice of Privacy Practices: Yes No

X _____
Patient Signature Date

Continue



Medicare Patient Authorization Notice

I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize Retina Associates of Cleveland, Inc as holder of any medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for these or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorized such physician or organization to submit a claim to Medicare for payment to me. I request that payment under the Medical Insurance Program be made directly to Retina Associates of Cleveland, Inc on any bills for services furnished me by Retina Associates of Cleveland, Inc during the full period of my treatment by any of the physicians and/or agents of Retina Associates of Cleveland, Inc.

Patient Signature

Date

Blue Cross/Blue Shield Authorization

I hereby authorize Blue Cross/Blue Shield of Ohio to pay on my behalf such insurance benefits covered under my contract for services provided by one or more physicians and/or agents of Retina Associates of Cleveland, Inc.

Patient Signature

Date