AUTHORIZATION FOR RELEASE OF INFORMATION FOR INSURANCE BENEFITS

I hereby authorize and direct Kenneth D. Boltz, O.D., LLC, having treated me, to release to government agencies, insurance carriers, or others, who are financially liable for my care, all information needed to substantiate payment for my care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.

X_____

Signature of Patient/Guardian or Legal Representative Date

ASSIGNMENT OF BENEFITS

I hereby assign, transfer, and set over to Kenneth D. Boltz, O.D., LLC sufficient monies and/or benefits to which I may be entitled from government agencies, insurance carriers, or others who are financially liable for my medical care to cover the costs of the care and treatment rendered to myself or my dependent. I understand that I am financially responsible for the charges not covered by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original. When signed by a Medicare recipient, this is a lifetime care authorization. This authorization may be revoked at anytime in writing.

X_____

Signature of Patient/Guardian or Legal Representative Date

ACKNOWLEDGEMENT OF HIPAA NOTICE OF PRIVACY PRACTICES

I,_____(print name of patient), acknowledge that I have been provided a copy of Kenneth D. Boltz, O.D., LLC Notice of Privacy Practices. In addition, I permit Kenneth D. Boltz, O.D., LLC, to give the person listed below access to my personal health information.

_____

Name Relationship

X_____

Signature of Patient/Guardian or Legal Representative Date