Madison Eye Care, LLC

Maria I. Diaz O.D. Eileen Bush O.D.

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Date_________

I hereby authorize Madison Eye Care, LLC or associate to furnish any and all records, medical history, services rendered, or treatment given to me or any dependent for purposes of review, investigation, or evaluation of any claim submitted to my insurance company.

I also authorize my insurance company to disclose to a hospital or health care service plan, or self-insurer any medical information obtained if such disclosure is necessary to allow the processing of the claim.

If my coverage is under a group contract held by an employer, an association, trust fund, union, or similar entity, this authorization also permits disclosure to them for purposes of utilization review or audit.

This authorization shall become effective immediately upon execution and shall remain in effect for the duration of any claim or term of coverage with my insurance company including a reasonable time thereafter, until its final consummation. This authorization shall be binding upon me, my dependents, and our heirs, executors, and administrators.

Medicare B

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration, or its carriers, any information required to process my Medicare claims. I request that payment under the Medical Insurance program be made to Madison Eye Care, LLC or associates.

PATIENT (or authorized) NAME____

PATIENT (or authorized) SIGNATURE____

HEALTH INSURANCE CLAIM NUMBER (Medicare ID)________________________