LALIN EYE
CATARACT & RETINA

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, assignment of payment, fee collection, and health care operations.

Person(s) Authorized to receive appointment reminders or medical information on your behalf (enter all that you approve):

Spouse:	**Parent:**	**Friend/Caregiver:**
_____	_____	_____

PRIVACY PRACTICES

I acknowledge the Notice of Privacy Practices of Lalin Eye is available for my review by request at the Front Desk.

PERMISSION TO BILL INSURANCE

I request that payment of authorized benefits be made on my behalf to Lalin Eye for any services furnished me by Sean Lalin, MD or Lalin Eye. I authorize any holder of medical information about me released to the payer and its agents any information needed to determine these benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance coverage is indicated on any approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In assigned cases, Sean Lalin, MD or Lalin Eye agrees to accept the charge determination of the payer as the full charge, excluding non-covered services. Coinsurance and deductible are based upon the charge determination of the payer.

PERMISSION FOR TEXT MESSAGES

By providing my mobile phone number, I authorize the practice to contact me by text message (SMS) regarding appointments, billing, care updates, and other healthcare-related communications. Message and data rates may apply. Consent is voluntary and may be revoked at any time by notifying the practice. It is my responsibility to notify the practice of any changes to my mobile number.

Name:_____**Signature:**_____**Date**:_____