AUTHORIZATION OF RELEASE/ASSIGNMENT OF BENEFITS
STATEMENT OF RESPONSIBILITY

I authorize the release of my medical records from Hawks Prairie Vision Clinic in order to process any claims. I hereby authorize my insurance benefits to be paid directly to Hawks Prairie Vision Clinic for services rendered. I understand that is my responsibility to follow the guidelines and to know the coverage and benefits of my medical and vision care insurance plans. I understand that as the patient (or the patient's parent/guardian) I am responsible for any unpaid balance on this account. I also understand that if any charges are not covered by insurance, workers' compensation or other third party payers, I am responsible for full payment.

SIGNATURE:________________________________ **DATE:**_______________

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

Hawks Prairie Vision Clinic keeps a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the office manager. Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By signing below, I acknowledge that I have received the Notice of Privacy Practices.

______________________________ ________________________
Patient or legally authorized individual signature Date

______________________________ ________________________
Printed name if signed on behalf of the patient Relationship

AUTHORIZION FOR RELEASE OF HEALTH INFORMATION
PURPOSE: For release of protected health information to a third party not involved with the payment, treatment or health care operations of the patient.

I authorize Hawks Prairie Vision Clinic to release my personal Health Information to the following individual(s) or facility:

______________________________ ________________________
Name Relationship

______________________________ ________________________
Name Relationship

______________________________ ________________________
Name Relationship

SIGNATURE:______________________________ **DATE:**____________________