Alaska EyeCare CENTERS

Patient Consent for Treatment and

Authorization to Use and Disclose my Health Information

1. The undersigned gives permission for any provider at Alaska Eye Care Centers, APC to provide treatment and perform procedures. These may include, but not limited to, eye health examinations, follow-up visits, dilation, treatment for eye disease, fitting for eyeglasses or contact lenses under the general and special instruction of the patient's Optometric physician.

2. I allow Alaska Eye Care Centers, APC to file for insurance benefits to pay for the care I receive.

   I understand that:
   - Alaska Eye Care Centers, APC will have to send my medical record information to my insurance company.
   - I must pay my share of the costs.
   - I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

3. I understand:
   - I have the right to refuse any procedure or treatment.
   - I have the right to discuss all medical treatments with my clinician.

4. I authorize the use or disclosure of my health information and to release copies of my medical records, eyeglass and/or contact lens Rx, and billing statements.

5. I authorize the release of any information including diagnosis and records of my treatment or examination to myself or other appropriate caregivers as I may request for coordination and continuity of care.

   ****Unless revoked, this consent and authorization will expire 365 days from the date of signing****

Patient's Name (Print):_____ DOB:_____

Patient Address:_____ Phone:_____

Patient's Signature:_____ Date:_____

Anchorage: 1345 W. 9th Avenue, Anchorage, AK 99501 Phone (907) 272-2557 Fax (907) 274-4932

Wasilla: 1700 E. Parks Hwy., Wasilla, AK. 99654 Phone (907) 376-5266 Fax (907) 373-1887