



AUTHORIZATION FOR BENEFIT ASSIGNMENT AND INFORMATION RELEASE

I hereby assign any benefits payable to Central Pennsylvania Eye Institute for providing medical services. I understand that I am responsible for any balance in excess of the benefits/contract payable by this plan.

The Central Pennsylvania Eye Institute may disclose information about me and the treatment I am receiving, including copies of my medical records, to: (1) my insurance carrier, (2) any person or firm which conducts reviews of my treatment on behalf of my governmental bodies to review hospital/physician utilization under the Medicare program. This information will be used by these parties to determine the medical necessity of the services I am receiving, to improve the quality of services provided, and to process payment for all or part of my hospital/physician bill.

This authorization applies to all visits to this practice site for this calendar year and all other services by Central Pennsylvania Eye Institute associated with those visits.

_____ DATE	_____ SIGNATURE	_____ NAME (Please print)	_____ RELATION TO PATIENT
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