Name and relationship of person who you wish to allow access - for example, your spouse, sibling, neighbor, care-taker, close friend: Phone # Relationship I understand that information used or disclosed pursuant to this authorization may be disclosed by Eye Clinic of Meridian, PLLC and may no longer be

I understand that I have the right to revoke this authorization in writing, at any time by sending such a written notification to the practice's Privacy Contact. I

My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except: (1) If my treatment is related to research, or (2) health care services are provided to me solely for

Signature of Patient or Personal Representative

Print Name of Patient or Personal Representative

protected health information to the following persons and/or entities listed below. If no one is listed below, protected health care information will not be disclosed except in those situations described in the notice of privacy Practices of Eye Clinic of Meridian, PLLC.

Name of Person or Entity

This authorization to use and disclose this protected health information is being submitted by my request and shall be in force and effect until revoked in writing by me, or, if the purpose of the disclosure is related to research, at the end of the research study.

protected by federal or state law.

understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure if the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

the purpose of creating protected health information for disclosure to a third party.

Eye Clinic of Meridian, PLLC

Cassie N. Confait, M.D Board Eligible, American Board of Ophthalmology

Eric J. Johnson, II, O.D

Butler Eye Center Livingston Eye Center STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER OR PHYSICIAN

Date Signed ____

STATEMENT TO PERMIT PAYMENT OF PRIVATE/GROUP INSURANC OTHER INSURANCE BENEFITS TO PROVIDER OR PHYSICIAN.	CE, MEDICAID, MEDIGAP, OR SUPPLEMENTAL INSURANCE OR ANY
PATIENT NAME	
I request that payment of authorized Medicaid, Medigap, or any other suppler providers for services furnished me by either physician (DON E. MARASCALC JOHNSON, II, O.D.). I authorize THE EYE CLINIC'S providers to release Me information about me needed for payment of medical insurance benefits. I rec	CO, M.D., J. LAWRENCE MASON, JR., M.D., CASSIE N. CONFAIT, M.D., ERIC J. dicaid, Medigap, or any other insurance carrier, any medical or other
I certify that the information given by me in applying for payment is correct.	
SIGNATURE	Date Signed
ACKNOWLEDGEMENT FORM	
I have received the Notice of Privacy Practices and I have been provided an o	pportunity to review it.
Name	Birth date
Signature	Date Signed
AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFO	RMATION
I authorize my physician and/or administrative and clinical staff of the Eye Cl	



I request that payment of authorized Medicare benefits be made on my behalf to THE EYE CLINIC'S providers for services furnished me by either physician (DON E. MARASCALCO, M.D., J. LAWRENCE MASON, JR., M.D., CASSIE N. CONFAIT, M.D., ERIC J. JOHNSON, II, O.D.). I authorized any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or

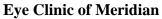
Don E. Marascalco, M.D.

the benefits payable for related services. SIGNATURE _

PATIENT NAME

J. Lawrence Mason, Jr., M.D.

Diplomate, American Board of Ophthalmology



Certified Therapeutic Optometry

Description of Personal Representative's Authority

Date

Diplomate, American Board of Ophthalmology