Specialized Pediatric Eye Care & Adult Strabismus

LIFETIME INSURANCE AUTHORIZATION AND RELEASE FOR MEDICAL INFORMATION

I REQUEST THAT PAYMENT OF THE AUTHORIZED HEALTH INSURANCE BENEFITS (EG: MEDICARE, MEDICAID, MEDEX BLUE SHIELD, WORKMAN'S COMPENSATION, COMMERCIAL, ETC.) BE MADE TO ME OR ON MY BEHALF TO SPECIALIZED PEDIATRIC EYE CARE, INC. FOR ANY SERVICES FURNISHED BY THE PHYSICIANS AND STAFF EMPLOYED THERE.

I AUTHORIZE ANY INSURANCE CARRIER AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

ONCE SPECIALIZED PEDIATRIC EYE CARE HAS OBTAINED MY ONE-TIME AUTHORIZATION, THEY MAY SUBMIT ANY LATER INSURANCE CLAIMS ON EITHER AN ASSIGNED OR NON-ASSIGNED BASIS, WITHOUT SUBMITTING CLAIMS, THEY SHOULD INDICATE IN THE PATIENTS SIGNATURE SPACE:

Patient Signature or Authorized Signer	Today's Date
Account #	Date Of Birth