PACIFIC NORTHWEST RETINA

Release of Information:

I give permission to the following person/persons to speak with anyone from Pacific Northwest Retina about my eye condition, billing information, and any other relevant information.

1. Name & Relationship: _____

2. Name & Relationship: _____

3. Name & Relationship: _____

Patient Initials:_____

Financial Agreement: I acknowledge that I have received and reviewed the Financial Policy.

Patient Initials:_____

Referral Policy: I, the undersigned, realize that my insurance may require a referral/authorization before it will pay for this visit. If any referral and/or authorization is required and not received for this visit, I understand that I am responsible for the total amount of this exam.

Patient Initials:_____

Acknowledgement of Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose the medical information that we maintain about you. It also explains how you can access this information.

By signing, you acknowledge that you have reviewed the Notice of Privacy Practices of Pacific Northwest Retina.

Print Patient's Name: **Date of Birth:**

Signature of patient or guardian **Date**