Please read the following statements and sign:

I authorize release of medical information. I consent to photography. This authorization shall be binding indefinitely from the date of signature. A copy of this release will be as legal and binding as the original.

I understand that all office visits are to be paid at the time services are rendered. I also realize that I am responsible for payment before filing my insurance. For any services rendered I request that payment of authorized Medicare, Medicaid, and /or insurance benefits be made to Northside Eye Care. I authorize any holder of medical or other information about me to release to Health Care Financing Administration, insurance company and its agents any information needed to determine these benefits or benefits for related services.

Due to danger to myself and others, I realize I should not drive while my eye is dilated, medicated or patched.

Signature: ____ Date_____________