



# PRIMARY EYE CARE CENTERS

Treatment & Management of Ocular Disease

1641 N. ALPINE ROAD SUITE 205  
ROCKFORD, IL 61107  
PHONE 815-397-5337 FAX 815-397-5540

## HIPPA FAMILY/PATIENT INFORMATION RELEASE FORM:

In compliance with the new HIPPA law, any person that is age 18 years or older are required to give written permission to their medical care providers to release information regarding: (please **initial** the ones you are approving)

\_\_\_\_\_ Their private billing account ledger, including all charges and all balance amounts with Primary Eye Care Centers, p.c./ and or their billing firm.(verbal or written )

\_\_\_\_\_ Any information regarding their insurance account with **Primary Eye Care Centers** including all charges, testing, balance and conversations or EOBs from my insurance carrier/s and/or their billing office ( verbal or written ).

\_\_\_\_\_ Any information pertaining to my medical treatment and diagnosis (verbal only)

\_\_\_\_\_ Copies of my complete medical files (written only).

\_\_\_\_\_ Permission to pick up my eyeglass prescription (written only) and/or any items such as eyeglasses or contacts that have been ordered and are ready for pick up.

By signing this form, I am giving permission to release only the specific information ~~initial~~ <sup>initial</sup> +above regarding my account and/or my medical records with Primary Eye Care Centers, p.c./and or their billing company to the following person/s listed below.

I also understand that I may rescind this permission at any time with written notice to Primary Eye Care Centers, p.c.:

\_\_\_\_\_/\_\_\_\_\_  
Name Relationship

\_\_\_\_\_/\_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Office Personnel (Witness )

\_\_\_\_\_  
Date