Referred by: ____

I have read and accept Advance Eye Surgeons' Privacy Policy, which insures that my medical records will be released only to my Insurer, and authorize the release of medical information to them in order to determine benefits. I request the payment of authorized insurance benefits be made on my behalf to Advanced Eye Surgeons for any services provided. I understand that my records will not be released to anyone else without my written authority.

Lifetime Medicare Signature: ____ Date: ____________________

Primary/Supplementary Insurance Signature: ________________________________ Date: ____________________