center for sight
keeping your world in focus

Patient Authorization

I hereby authorize payments directly to Center for Sight, Inc. for the surgical / medical benefits, if any, otherwise payable to me for their services.

I hereby authorize Center for Sight, Inc. to release any medical information necessary to process claims.

I understand that I am financially responsible for the charges not covered by this authorization.

_____ _____
Signature of Patient, Parent, or Responsible Party Date

I hereby acknowledge having received a copy of Center for Sight's Privacy Notice

_____ _____
Signature of Patient, Parent, or Responsible Party Date

Below are the names of family members or other persons allowed to be informed about my eye care and diagnosis.

_____ # _____
_____ # _____
_____ # _____

_____ _____
Signature of Patient, Parent, or Responsible Party Date