IDEALEYES
EST. 2020

AUTHORIZATION & CONSENT TO TREAT

I authorize my doctor and their designated staff to perform examinations for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all tests required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired during my examination and treatment to my other doctors and/or insurance carriers.

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to the office named on the benefits otherwise payable to me.

_____ _____

Signature of patient or authorized representative **Date**

_____ _____

Authorized representative's name **Relationship**

Updated: May 1st, 2022