NORTHERN EYE CARE
ASSOCIATES

By signing this form, you are acknowledging that Northern Eye Care Associates, P.C. has made the Notice of Privacy Practices available to you for review and that they have offered you a personal copy.

Patient Name:_____

Signature:_____ Date:_____

I authorize the release of information related to my diagnosis, treatment, claims payment, current health care services and future services to the following:

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