

Patient Authorization

I hereby authorize payment directly to Gordon W. Jennings OD PC for the surgical/medical benefit, if any, otherwise payable to me for their service.

I hereby authorize Gordon W. Jennings OD PC to release any medical information necessary to process claims.

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

Initials\_\_\_\_\_\_

I hereby acknowledge having received a copy of Gordon W. Jennings OD PC Privacy Notice.

Initials\_\_\_\_\_\_

Below are the names of family members or other persons allowed to be informed about my eye care and diagnosis or in the event of an emergency:

Name(s) Relation to Patient Phone Number(s)

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 Patient/Parent or Guardian Signature Date