EYEXAM OF CALIFORNIA

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AUTHORIZATION FOR REQUEST OF CONFIDENTIAL COMMUNICATION OF MEDICAL INFORMATION

I request access as the ☐ Patient ☐ Parent/Guardian ☐ Authorized Assistant (Proof of legal documentation is required)

____ _______________________________________
Name of Patient (Please print clearly) Date of Birth

____
Address City State Zip Code

(_____) _____________________
Contact Number

Today's Date: __________________

Communication this request will cover for confidentiality

- Bill
- Notice of adverse benefit determination
- Explanation of Benefits
- Information regarding claims
- Notice of contested claims

Preferred method of communication:

☐ Written: Address to send correspondence: ____

☐ Electronic: Email to send correspondence: ____

☐ Verbal/live: Telephone contact to send correspondence:
____

Duration: This authorization is valid until the subscriber or enrollee submits a revocation of the request or a new confidential communication request is submitted, without an annual renewal requirement.

Date: __________________

Patient Name (Print): _____________________________ Daytime contact #: ____________________

____ _________________________________

Signature of patient or patient's representative relationship to patient