REDMAN GELINAS
EYE CARE

PATIENT: _____ ACCOUNT: _____

AUTHORIZATION TO RELEASE

I authorize Redman & Gelinas S.C., D.B.A. Eye Care Associates, to release information regarding my medical diagnoses and treatment to my insurance company for the purpose of facilitating the payment of insurance benefits or to submit a claim for services on my behalf. I further authorize payment be made directly to Redman & Gelinas S.C./Eye Care Associates when requested.

This authorization will remain in effect until revoked by written request.

_____	_____
Subscriber Name	Insurance Company Phone
_____	_____
Policy/Employer	Insurance Company Address
_____	_____
Group	Insurance Company Address
_____	_____
SIGNATURE	DATE

RESERVED SPACE BELOW FOR PHOTOCOPY OF INSURANCE CARD(S)