

**LONG ISLAND EYE SURGICAL CARE, P.C  
AUTHORIZATION AND USE OF SIGNATURE**

\_\_\_\_\_  
Subscriber Social Security Number

\_\_\_\_\_  
Subscriber Name

I, \_\_\_\_\_, authorize \_\_\_\_\_.  
Subscriber Name Provider Name

A. To mark the section "SUBSCRIBER'S OR AUTHORIZED PERSON'S SIGNATURE" with the notation "SIGNATURE ON FILE".

B. This section authorizes:

- 1) The release of any medical information necessary to process this claim.
- 2) Payment of medical benefits to the undersigned physician or supplier of services described below.
- 3) Long Island Eye Surgical Care, PC; or a duly designated agent or employee or officer thereof to act as my designee ("Designee") for all permitted purposes as set forth in New York State Insurance Law and New York State Public Health Law, including but not limited to internal and external appeals on adverse determinations regarding my healthcare.

These authorizations contained in section A and Section B will remain in force until terminated in writing by the subscriber.

\_\_\_\_\_  
Subscriber Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature