AUTHORIZATION TO RELEASE MEDICAL INFORMATION

IMPORTANT PLEASE READ: This form authorizes your health care provider to release health information regarding your care or treatment to the individual or organization you identify as set out below:

This form is for the medical records of:

Patient Name:____

Last First Middle/Maiden

Address:____

Date of Birth ____________________ Phone: ________________

I hereby authorize Happy Vision Eye Clinic to: (check one)

[ ] **Provide** records to: Please print the name/address of person or organization below

[ ] **Obtain** records from: Please print the name/address of person or organization below

Phone: Fax:

I UNDERSTAND THIS AUTHORIZATION MAY BE REVOKED AT ANY TIME EXCEPT TO THE EXTENT ACTION HAS BEEN TAKEN BASED UPON IT. THIS AUTHORIZATION WILL EXPIRE IN 60 DAYS FROM THE DATE SIGNED UNLESS OTHERWISE SPECIFIED:_______________________________

Information used or disclosed because of this authorization may be further disclosed by the recipient and therefore no longer protected.

Signature by patient:		Date:
Signature by parent/guardian:	/relationship:	Date:
If Patient Unable to Sign: Witness:		Date: