Eye Care Associates - Medical Information Release

Name:_____ DOB ___/___/_____

Email (please print clearly): _____

Release of Information

[ ] I authorize the release of information including the diagnosis, records, examination rendered to me and claims information may be released to:

[ ] Spouse/Partner _____

[ ] Parent/Guardian_____

[ ] Child(ren)_____

[ ] Other _____

[ ] Information is not to be released to anyone.

Signature: _____ Date: _____

This Release of Information will remain in effect until form us updated or until terminated by me.