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RECORDS RELEASE AUTHORIZATION

I hereby authorize _____to release copies of my records.

Please mail;
_____
_____
_____

Do not fax to Brunswick Eye Care if record is more than ten pages-thank you

Reason for Release
( ) continuation of Medical Care ( ) Legal Purposes ( ) Insurance Purposes ( ) Other

Information Requested

( ) Last 2 office visits ( ) All Records ( ) Glasses Prescription ( ) Test Results

( ) Contact Lens Prescription ( ) Operative Reports ( ) Photos

This authorization must be signed and dated and may be revoked by notifying us in writing. This consent will expire 60 days from the date signed.

I understand that the medical record released pursuant to this authorization could contain information concerning drug related conditions, alcoholism, psychological conditions, psychiatric conditions and/or blood borne infectious disease, which are subject to federal and/or state restrictions on disclosure. I understand that if the person or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. I hereby affirm that I have read and fully understand the above statements and consent to the disclosure of the medical record for the purpose and extent stated above.

Patient Name _____ Date of Birth _____

_____ Date _____
Signature of patient, parent or POA (attach copy of POA)

Relationship to patient_____