TURLOCK EYECARE OPTOMETRIC CORPORATION

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name:_____

Patient DOB: _____

I authorize the disclosure of my personal health information to the person/entities as described below. I understand this authorization is voluntary and can be revoked at any time in writing, addressed to the contact information listed above.

You have the right to determine an expiration date for this authorization. If no date is listed this authorization will be in effect indefinitely, or until revoked. Expiration date_____

I authorize disclosure to the following people/entities:

1. Name _____Relation to patient:_____

Address _____Contact #:_____

2. Name _____Relation to patient:_____

Address _____Contact #:_____

3. Name _____Relation to patient:_____

Address _____Contact #:_____

4. Name _____Relation to patient:_____

Address _____Contact #:_____

By signing below, I confirm the release of my information to the entities listed, and I attest the information listed is, to the best of my knowledge, current and accurate.

Signature: _____ Date: _____

If a personal representative on behalf of the individual signs this authorization, complete the following and attach a copy of legal authority if applicable.

Representative's Name:_____Relation to the Patient: _____