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Optix Eyecare Center

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(Please be advised that our staff cannot speak with anyone that is not listed on this form.)

Print Patient Name_____Date of Birth_____

I am authorizing Optix Eyecare Center to release my medical information to the following persons if I am not available.

Name_____Relationship_____

Name_____

Relationship_____

Name_____

Relationship_____

_____ I do not wish to have my information released to anyone besides myself.

Please sign and date below:

Signature:_____

Date:_____ Relationship to patient:_____