



*Advanced eye care with a home-town touch*

**2377 LENORA CHURCH ROAD  
SNELLVILLE, GEORGIA 30078  
770.979.2020  
CARLINVISION.COM  
FOLLOW US ON FACEBOOK  
FAX: 770.978.3321**

**AUTHORIZATION FOR AND CONSENT TO RELEASE INFORMATION**

I, the undersigned patient/guardian, hereby authorize \_\_\_\_\_  
to release information from the records of \_\_\_\_\_.

Please release records to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*I understand this authorization includes release of all medical records including HIV, Psychiatric Mental Illness, Drug/Alcohol Abuse, Venereal Disease and any other statutory protected diseases. This authorization and consent will expire ninety (90) days following the date signed. I understand that I may revoke this authorization and consent at any time except to the extent that action has previously taken in reliance hereof.*

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Date of Signature

\_\_\_\_\_  
Patient Date of Birth

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Signature of Witness