CARLINVISION
Advanced eye care with a home-town touch
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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.

_____ _____

Print Name of Patient Signature of Patient or Guardian

_____ _____

Patient Date of Birth Date of Signature

_____ _____

Relationship to Patient Signature of Witness