John Day Eye Care

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Authorization for the Release of Identifying Health Information

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Patient phone number(s):_____

I authorize _____ to release health information identifying me under the following terms and conditions:

- Detailed description of the information to be release:

- To whom the information may be released:

- Expiration date of release, if any:

If you sign this authorization, you can revoke it later at any time. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization please send our office a written and signed notice.

By signing you agree with and understand the above statements.

If you are signing as a personal representative of the patient please note your relationship and/or authority for signing for the patient.

Name of signer: _____ Relationship: _____

Signature: _____ Date: _____