SOUTHWEST EYECARE

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AUTHORIZATION FOR RELEASE OF EYECARE INFORMATION

Patient Name: _____ Date: ___ /___ /___

D.O.B. ___ /___ /___

_____ I authorize _____ to immediately release all information regarding my visual health to SouthWest Eyecare.

_____ I authorize SouthWest Eyecare, Inc. to release my visual health records to:

_____

_____

_____

Phone: _____ Fax: _____

Information to be released:

_____ All eye care and treatment records

_____ All eyeglass and contact lens specifications

_____ Other _____

I specifically consent to the release and disclosure of this information including transmission of my vision records via facsimile. Subsequent transfer of the records or disclosure of their content is prohibited without my specific consent.

Signature: _____ Date: ___ /___ /___

Relation if other than patient: _____

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