TOTAL EYECARE

Professional Eyecare Your Family Deserves
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AUTHORIZATION TO RELEASE RECORDS

Full Name:_____ Date of Birth:_____

Please check one:

____ I hereby authorize Total Eyecare to **release** any information including diagnosis and records of any treatment or examination rendered to me in the past.

____ I hereby authorize Total Eyecare to **obtain** any medical information from any physician, hospital, or other health care professional that have rendered to me in the past.

Dates requested: _____ to _____.

This will authorize Total Eyecare to **disclose** or **obtain** my records to/from:

_____ _____
Name Phone or Fax Number

_____
Address

_____
City State Zip

This facility, its employees, officers, and attending optometrists are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein. If you want this release to expire, please write in the expiration date:_____

_____ _____
Signature of Individual or Representative Date

_____ _____
Witness Date