duvall
advanced
family eyecare

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AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: Date of Birth:		
Previous Name:		
I request and authorize my health care information:		
☐ TO ☐ FROM Duvall Advanced Family Eyecare		
☐ TO ☐ FROM Name:		
Address:		
City:	State:	ZIP Code:
PH#	FAX#	
This request and authorization applies to: ☐ Health care information relating to the following treatment, condition, or dates:		
☐ Most recent eye exam and prescription information		
☐ All health care information		
☐ Other:		
Patient Signature: Date Signed:		
POA/Guarantor Signature: Date Signed:		
POA/Guarantor Relationship:		

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.