



Sara E. Low
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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:			
<input type="checkbox"/> TO <input type="checkbox"/> FROM Duvall Advanced Family Eyecare			
<input type="checkbox"/> TO <input type="checkbox"/> FROM			
Name:			
Address:			
City:		State:	ZIP Code:
PH#		FAX#	
<p>This request and authorization applies to:</p> <input type="checkbox"/> Health care information relating to the following treatment, condition, or dates:			
<input type="checkbox"/> Most recent eye exam and prescription information			
<input type="checkbox"/> All health care information			
<input type="checkbox"/> Other:			
Patient Signature:		Date Signed:	
POA/Guarantor Signature:		Date Signed:	
POA/Guarantor Relationship:			

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.