TOTAL EYECARE

Professional Eyecare Your Family Deserves

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AUTHORIZATION TO RECORDS RELEASE

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.

____ ______________________
Signature of Individual or Representative Date

____ ______________________
Witness Date