AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

Patient Name: ______________________ Date of Birth: ______________

I hereby request and authorize 307 Vision to:

☐ Disclose information to: ☐ Receive information from:

Provider: ______________________
Address: ______________________
City: __________ State: ______ Zip: __________

Information to disclose includes copies of:

- ☐ Medical records
- ☐ Eyeglasses prescription
- ☐ Contact lens prescription

______________ ______________________
Date Patient's Signature

If you are signing as a legal representative of the patient, describe your relationship to the patient.

______________ ______________________
Date Legal Representative's Signature

____
Relationship to Patient

If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.

Notice to recipient of information. This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosures of this information without the specific written consent of the patient or legal representative.

Ph: (307) 266-9988

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Casper, WY 82609

Fax: (307) 266-9992