AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

I hereby request and authorize Family Eye Wellness
to release the ALL records of treatment I have received to:

_____

(Doctor/Practice Name) **(Fax Number)**

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Family Eye Wellness. I understand that the revocation will not apply to information that has already been released in response to this authorization I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire 1 year from the date signed.

X _____

Signature of Patient/Parent/Authorized Representative **Date**
(Guardian or Authorized Representative must attach documentation of such status)

_____

Printed name of Patient/Parent/Authorized Representative **Relationship to Patient**

Date of Birth: _____