Pasco Vision Clinic, P.S.

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CONSENT FOR RELEASE OF MEDICAL INFORMATION

PATIENT: _____

DATE OF BIRTH _____

TO: _____

_____

FROM: _____

_____

Please include the following information:

☐ **All Clinical Records**

☐ **Clinical Records only related to:** _____

☐ **Ocular Health Status**

☐ **Most Recent Refraction and/or Contact Lens Specification**

Other _____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY . I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM. RECORDS MAY TAKE UP TO 7 BUSINESS DAYS.

This authorization expires 60 days from the date of the request.

Patient Signature _____

Relationship _____

Date _____