Focused Eye Care
NASHUA & MILFORD

Authorization to Release Medical & Financial Information

Name: _____ Date of Birth: _____

HIPAA privacy regulations require Focused Eye Care to have a release signed by our patients so we may speak with family members, friends and other relations regarding your medical treatment and financial information.

Please print first and last name and the relationship for each individual to whom you are authorizing release of the above information.

Name (First & Last)	**Relationship**
1.	
2.	
3.	
4.	
5.	

I understand that I may revoke this consent at any time, except where information has already been released. This authorization is valid for a sixty (60) day period from the date that it is signed.

Signature: _____ Date: _____
Patient (Parent/Legal Guardian if a Minor)

Kelly M. MacDonald O.D. Scott D. Huffer O.D.|F.A.A.O. Sarah E. Jagatic O.D.
Philip S. Aubrey O.D. Anjelica M. Donnelly O.D. Kristen O. Bryant O.D. Kendra M. Phillis O.D.
505 West Hollis Street | Suite 109 | Nashua NH 03062 | P: 603.882.0311 | F: 603.882.3020 |
abettervision.com
81 Mont Vernon Street | Milford NH 03055 | | 603.673.1330