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.

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

FEC-MFR-021023

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