OPTOMETRIC SPECIALTY GROUP, LLC.
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AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name: ____

Date of Birth: ____

I authorize the individual or company identified in section 2 to release my medical records to **Optometric Specialty Group** under the following terms and conditions:

1. Detailed description of the information to be released: (check box)

   ☐ Entire medical record including all ancillary testing and all contact lens records.
   ☐ Specific medical records: ______________________________

2. Individual or company to release records:

   Name: ______________________________
   Doctor: ______________________________
   Address: ______________________________
   City/State/Zip: ______________________________
   Phone: ______________________________
   Fax: ______________________________

3. The purpose for the release: (check box)

   ☐ At my request.
   ☐ Other (specify): ______________________________

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED ABOVE. THE DISCLOSED INFORMATION IS PROTECTED BY LAW AND THE DISCLOSURE IS TO BE MADE TO CONFORM TO MY INSTRUCTIONS.

______________________________ ______________
Signature Date