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Hunter's Hill Eyecare Center

2811 N George St, Suite B
York, PA 17406
P: 717-848-2323
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Records Release to Hunter's Hill Eyecare Center

I, (Name/DOB) _____ Authorize:

Practice Name: _____

Phone: _____

Fax: _____

To release my medical records to:
Hunter's Hill Eyecare Center
2811 N. George St, Suite B
York Pa 17406
P: 717.848.2323
F: 717.846.0844

Please have my complete medical record including results of diagnostic testing, a copy of the glasses and contact lens prescriptions sent to Hunter's Hill Eyecare Center.

I HAVE READ AND UNDERSTAND THIS FORM. I VOLUNTARILY AUTHORIZE THE DISCLOSURE OF MY PERSONAL HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Print Patient Name/DOB: _____

Signature/Today's Date: _____

I AM SIGNING FOR A MINOR/INDIVIDUAL UNABLE TO SIGN FOR THEMSELVES, I ATTEST THAT I HAVE LEGAL AUTHORITY TO MAKE DECISIONS FOR THE ABOVE LISTED INDIVIDUAL.

Printed name of authorized individual: _____

Relationship to patient: _____