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## Authorization for Release of Medical Records

I, (Name/DOB) \_\_\_\_\_ authorize Hunter's Hill Eyecare Center to release my medical records to the following office.  
Please note that all records will be faxed unless otherwise specifically requested.

Practice Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

They will receive the following from our office:

- Copy of your complete medical record including results of diagnostic testing
- Copy of glasses and contact lens prescription.

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: \_\_\_\_\_