AUTHORIZATON FOR THE RELEASE OF CURRENT MEDICAL INFORMATION

Advanced EyeCare Center, PC
4660 86th Street
Urbandale, IA 50322

515-727-6340
fax 515-727-5109
Direct Address: Wendianne.Wilson@direct.revolutionehr.com

Patient: _____ Date of Birth: _____/_____/_____

Current Address: _____ Telephone #: _____

City: _____ State: _____ Zip _____

I hereby authorize _____ to release the health information indicated below that is contained in my patient records to Advanced EyeCare Center, PC.

Reason for disclosure

_____Medication List

This consent is subject to revocation at any time except to the extent the action has been taken thereon. This authrization and consent will expire one year from the date of authorization written below.

_____

Signature of Patient/Patient's Representative Printed Name Date Signed

_____

Relationship if not Patient