Within Sight Vision Center, P.L.L.C.

Authorization to Release Information

Patient Name: ______________________ **DOB: ____________________**

I hereby authorize Within Sight Vision to (check one): _____ obtain the following from
_____ release the following to

Name: ____

Phone number: ____

Fax: ____

Documents needed:

- ▢ Glasses prescription
- ▢ Contact lens prescription
- ▢ Most recent exam
- ▢ Entire medical record

I understand that my authorization will remain effecgive from the date of my signature until ________________, and that the information will be handled confidentially in compliance with all applicable laws.

I understand that I may see the information that is to be sent, and that I may revoke the authorization at any time by written and dated communication.

I have read and understood the nature of this release.

____ ____________________________

Signature of patient or patient's guardian **Date**