Authorizations To Release Medic al Information

To Provider or Facility from Chang Eye Group

Patient Name:_____ Date of Birth:_____Phone:_____

I authorize the release of the following protected health information:

____Office notes ____Visual field results ____Eyeglasses/contact lens prescriptions

Other:_____

The purpose for this request to release medical information is:

____Transfer of care ____ Insurance ____Other

Send my medical information to:

Name of Provider or Facility: _____

Address:_____ City/State/Zip Coe:_____

Phone:_____ Fax:_____

_____ _____

Patient/Representative Signature Date