Medical Records Release

Mountain View Vision
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I _____ (patient full name) authorize the above-named provider/entity to release the following designated medical information.

Information to be Released

- Copy of complete medical records including results of diagnostic testing
- Copy of contact lens prescription
- Copy of spectacle lens prescription
- Other information_____

Release Authorized to:

Practice Name: _____

Address: _____

City: _____, State: _____ Zip: _____

Secure email: _____

Fax: _____

I HAVE READ AND UNDERSTAND THIS FORM. I VOLUNTARILY AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM. IF I AM SIGNING FOR A MINOR CHILD, I ATTEST I HAVE LEGAL AUTHOIRTY TO MAKE MEDICAL DESIGNATIONS FOR THE DESIGNATED MINOR.

_____
Print Patient Name. DOB (unless signing for minor)

_____ Date _____ / _____ / _____
Patient or legally authorized individual signature

_____
Printed name if signed on behalf of the patient Designate parent or guardian DOB of minor (if signing for minor)