



6167 Bayfield Parkway, Concord, NC 28027
Phone: (704) 795-3937 Fax: (704) 795-1577

RELEASE OF HEALTH INFORMATION AUTHORIZATION

RECORDS RELEASE FROM:

Office: _____

Doctor: _____

Address: _____

p: _____ F: _____

INFORMATION TO BE DISCLOSED: (check all that apply)

☐ Medical and/or Exam Records

☐ Glasses Prescription

☐ Contact Lens Prescription

Patient Name: _____

Last

First

Middle

Address: _____

No. & Street Name

City

State

Zip Code

Date of Birth: _____

Home/Cell Phone: _____

By my signature below, I hereby authorize the above persons to use or disclose my health information to the recipient. I also acknowledge that if glasses and/or contacts are purchased outside our office, a minimum of a \$29 service fee will be charged if Doctor or Staff Professional services are needed. Prescription changes must be requested within 30 days of exam. I understand that by signing this release, my prescription information may be released upon request without any further authorization by me. I may revoke this authorization at any time by notifying Invision Family Eyecare in writing.

Signature of Patient (Parent or Guardian if patient is a minor)

Date

Printed Name

Relationship to Patient