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

RELEASE OF HEALTH INFORMATION AUTHORIZATION

RECORDS RELEASE TO:

Office:_____

Doctor:_____

Address:_____

_____

p:_____F: _____

RECORDS RELEASE FROM:

Invision Family Eyecare

LaSheta P. David, O.D.

6167 Bayfield Pkwy

Concord, NC 28027

P: 704-795-3937 F: 704-795-1577

INFORMATION TO BE DISCLOSED: (check all that apply)

- o Medical and/or Exam Records
- o Glasses Prescription
- o 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 hear by 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