

Eye Center of Northern Colorado
Authorization to Release Medical Information

Patient Name: _____
(Print) Last First Middle

Soc. Sec. # _____ Telephone # _____ Date of Birth: _____

Send information to: (name of person, organization or agency with full address) _____

Name: _____

Attn: _____ Telephone # _____

Address: _____

City _____ State _____ Zip _____

Purpose of release (continued care, referral, etc)

Describe the information desired to be released

I hereby authorize the Eye Center of Northern Colorado to release the specified information as stated in this authorization.

This authorization is for release of medical records and information including diagnosis, treatment, and/or examination related to mental health, drug and/or alcohol abuse, HIV testing/AIDS and sexually transmissible diseases.

I understand that this authorization will remain in effect for 30 days from the date of signature or until I revoke it.

I hereby release the Eye Center of Northern Colorado and its employees from any and all liability that may arise from the release of information as I have directed.

Patient Signature: _____ Date: _____

Signature of Parent or Guardian _____ Date: _____

Relationship to Patient: _____

Witness: _____ Date: _____