LAKEPOINTE VISION CENTER

Authorization for Release of Medical Information

_____

Patient Name

_____ _____

Date of Birth Social Security Number

I hereby authorize:

_____

Doctor / Medical Group / Hospital / etc

_____

Street Address City State Zip Phone

To release the following information to:

Lakepointe Vision Center
Dr. David S. Eghigian
1003 E. Wesley Dr. Ste A
O'Fallon, IL 62269
Ph: (618) 624-3937
Fax: (618) 624-3940

Information to be released:

___ All Medical Records
___ Current Prescription for Glasses and / or Contact Lenses
___ Last Comprehensive Examination Record
___ Other Specific Information
(explain)_____
_____
_____
_____
_____

By signing this waiver, I authorize release of private medical information to Lakepointe Vision Center, as stated above. I understand that this authorization expires in six months from the date of signature, unless I otherwise specify or revoke the authorization. I understand that I have the right to withdraw this authorization at any time by providing Lakepointe Vision Center and the above mentioned party with a written and dated notice. Any release of information made prior to the receipt of the withdrawal notice will be considered in compliance with this release. I also understand that the party releasing my medical information may require further documentation before complying with my request.

_____ _____

Signature of Patient / Guardian Date Signature of Witness Date

_____

Relationship to Patient