HOSPITALITY EYECARE
CENTER of OPTOMETRY

ph 909 383 5000
fx 909 383 5010

164 W Hospitality Lane, Suite 7
San Bernardino, CA 92408

www.SeeToLive.com

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name _____DOB_____

Address _____

Phone Number _____

I authorize _____to release my health

information to Hospitality Eyecare Center of Optometry.

Information to be released:
- ☐ Copy of completed records
- ☐ Copy of spectacle RX
- ☐ Copy of contact lens RX

Comments:

It is completely your decision to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon this authorization. If you want to revoke your authorization, send us a written note telling us that your authorization is revoked.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THIS DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient Signature _____Date _____