Desert Family
EYE CARE
SEE WELL • FEEL WELL • LIVE WELL

Authorization to Release Medical Information
From: Desert Family Eye Care / Reed Family Vision Center
To: Designated Person(s)

Patient Name: _____ DOB: _____

Address: _____

Home Phone #: _____ Cell Phone #: _____

I, _____, authorize Desert Family Eye Care, Reed Family Vision Center, my doctor, and his staff to discuss my medical care information as noted below, with the following person(s):

_____ _____
Name of Designated Person Relationship to Patient

□Person may receive information □Person may pick up glasses/contact lenses

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_____ _____
Name of Designated Person Relationship to Patient

□Person may receive information □Person may pick up glasses/contact lenses

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_____ _____
Name of Designated Person Relationship to Patient

□Person may receive information □Person may pick up glasses/contact lenses

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Signature: _____ Date: _____

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