HIPAA release form

I_____DOB_____hereby allow_____to use and disclose protected health information to Sharp Eyes Family Vision Center PLC.

This authorizes the release of information from_____to_____,
Or
_____ information from all past and future visits.

This includes copies of ___all medical records.
___medical records related to
(Please specify)_____

This information may be used for medical treatment or consultation or for billing purposes or at the request of the individual. I understand that I have the right to revoke this authorization at any time in writing.

Signature_____ Date_____

Relationship to patient_____