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**AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION**

(Check One)

- Release** - Releasing information from CVC to you or your provider  
 **Request** - Requesting information from another provider to CVC

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
**Street Address:** \_\_\_\_\_  
**City, State, Zip:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

I authorize Christenson Vision Care to  
**OBTAIN** my medical records **FROM:**

I authorize Christenson Vision Care to  
**SEND** my medical records **TO:**

\_\_\_\_\_  
 Name of Physician or Facility

\_\_\_\_\_  
 Name of Physician or Facility

\_\_\_\_\_  
 Street Address

\_\_\_\_\_  
 Street Address

\_\_\_\_\_  
 City, State, Zip

\_\_\_\_\_  
 City, State, Zip

\_\_\_\_\_/\_\_\_\_\_  
 Phone & Fax #

\_\_\_\_\_/\_\_\_\_\_  
 Phone & Fax #

(Check One)

- Include All Records  
 Include Only Records Between The Dates Of \_\_\_\_\_ And \_\_\_\_\_  
 Include Only Detailed Information As Follows:

\_\_\_\_\_

**X** \_\_\_\_\_ **Date:** \_\_\_\_\_

Signature of patient or patient's authorized representative

Relationship of representative (check one)  Parent  Legal Guardian or Executor (include copy of appointment)

For Office Use Only

Release Date/Initials: \_\_\_\_\_ / \_\_\_\_\_  Mailed  Faxed  By Patient