Garrett Eye Clinic

***COMPLETE** EYE CARE*

AUTHORIZATION TO RELEASE MEDICAL RECORD/INFORMATION

PHYSICIAN TO RELEASE RECORDS:
JENNIFER H GARRETT, MD / MEREDITH RHODES, OD

PATIENT'S NAME : _____

SOCIAL SECURITY #: _____

DATE OF BIRTH: _____

RELATIVE/FRIEND: _____

DATE: _____

I AUTHORIZE THE HEALTH CARE PROVIDER'S OF GARRETT EYE CLINIC TO RELEASE THE INFORMATION CONTAINED IN MY RECORDS TO THE PERSON NAMED ON THIS REQUEST. I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANYTIME. A COPY OF THIS AUTHORIZATION MAY BE UTILIZED WITH THE SAME EFFECTIVENESS AS AN ORIGINAL.

PATIENT'S NAME : _____

PATIENT'S SIGNATURE: _____

PERSON AUTHORIZED TO SIGN FOR A PATIENT: _____

DATE: _____

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