Concord Eye Care Center OD PA
Sonnie Bryant, O.D.

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name: _____

Patient DOB: _____

Today's Date: _____

List those who may inquire about your personal account, health information and appointments. Please include their relationship to you (example: spouse, parent, child, family friend.)

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Please indicate an expiration date or you may write "Open until Further Notice".

Expiration date: _____

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

Patient Signature: _____

If you are signing as a personal representative of the patient, describe your relationship to the patient.

Relationship to Patient: _____ Print Name: _____