VisionCare
- of Albany -

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Authorization Form for Release of Information

Attending Doctor:_____

I hereby agree that the above named doctor may disclose any and all information concerning my eye and visual status, while acting in a professional capacity, waiving all provisions of law to the contrary, including photographs.

I specifically give permission for the above named doctor to release the following:

- ☐ Exam records personally created
- ☐ My eyeglass and/or contact lens prescription
- ☐ Exam records and/or letters sent to or from doctors I was referred to
- ☐ My patient history form
- ☐ Order information from my last material purchase from your office

Patient's Full Name: _____

Current and/or Previous Address: _____

_____

Current Telephone Number: _____

Date of Birth: _____

Social Security Number: _____

Signature: _____ Date:_____

Thank you in advance,

Dr. Matt Hesse, O.D.