authorization to release health care info.

Patient Name ______________________________

Previous Name ______________________________

Date of Birth ______________ Phone ______________

I request and authorize (previous office) ______________________ to release health care information of the patient named above to:

Artisan Eyeworks
215 4th Street
Ashland OR 97520
Phone: (541) 708-5350
Fax: (888) 467-4348

This request and authorization applies to

- ◯ Complete medical records
- ◯ Glasses Prescription
- ◯ Contact Lens Prescription
- ◯ Other ______________________

I am requesting this information for

- ◯ Personal use
- ◯ Transferring Care
- ◯ Other (please explain) ______________________

Patient signature ______________________________

Date ______________________________

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER IT IS SIGNED