ODOM'S EYE CARE, PLLC
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Dr. D. McKinney-Evans
Treatment of Eye Disease

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Please complete the following information:

Patient Name: _____

Address: _____
_____
_____

Phone: _____

Date of Birth: _____

I authorize the records from: _____, for the above patient, to disclose/release the following information.

All Records:

Including laboratory/pathology records; Abstract /Summary records and Pharmacy/Prescription records.

Other: _____

Records are provided for the following date(s): _____

I understand that this authorization is voluntary and that I may refuse to sign at any time. By signing below I represent and warrant that I have authority to sign this document and authorize the use of disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____
Signature of patient (or patient's personal representative) Date

_____ _____
Printed name of patient representative Date