Senior Sight Inc.

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Patient Information:

Name: ____ Date of Birth: ________________________

Address 1: ____

Address 2: ____

City: _________________________________ State: ________________ Zip: _________________________

Phone: ____ Email: ____

This information is to be released TO:

____

____

City: _________________________________ State: ________________________ Zip: _________________

Information being requested:

___ Complete Record ___ Glasses Prescription ___ Contact Prescription

___ Records of care from the following Dates: _________________ to ____________________

I hereby authorize the information indicated on this form to be released from and to the indicated parties. I understand that this authorization shall be valid for one (1) year unless otherwise states on this form or through written notice to medical records. (Alternative date if not one (1) year: _______________). I understand that my medical record may contain reports, tests, results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information that has been written in the record. I will not hold Senior Sight Inc. liable for any misinterpretation of the information in my medical record as a result of not consulting my physical for the correct interpretion.

Patient Signature: ____ Date: ________________

Signature of Legal Representative: ____ Date: ________________

Relationship: ____