Please use this authorization to inform us of any persons you wish to have access to your private medical information. This authorization will allow our office to disclose, discuss, and release your information to those persons. This information includes, but is not limited to, medical records, prescriptions, receipts, billing inquiries, insurance inquiries, etc. Please include **everyone** you wish to have access to this information (i.e. Spouse, children, relatives,), as we will not release any information to a person who is not listed on this form. Please be advised that any changes to this authorization **must** be done in writing by filling out a new authorization. The new authorization will then void any previous authorizations.

Authorization for Release of Medical Information

Patient Name			
Date of Birth	Social Security Number		
I hereby authorize: Lakepointe Vision Center David S. Eghigian, O.D. 1003 E. Wesley Dr. Ste A O'Fallon, IL 62269 Ph: (618) 624-3937 Fax: (618) 624-3940			
To release my private medical in	formation to:		
Name:	Phone Number:	Date of Birth:	
		D	
authorize Lakepointe Vision Cindividuals. I understand that understand that I have the right Vision Center with a written a receipt of the withdrawal notion understand that once released, regulations.	this authorization will a at to withdraw this authorid dated notice. Any rece will be considered in	vate medical information to not expire, unless I otherwis orization at any time by pro elease of information made compliance with this release	se specify. I viding Lakepointe prior to the se. I also
Signature of Patient / Guardian	Date	Signature of Witness	Date
Relationship to Patient			