Authorization for Release of Medical Information

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.

_____ _____

Patient Name Date of Birth

_____

Social Security Number

I hereby authorize:
Lakepointe Vision Center
Nicholas Holtzman, M.S., O.D. **Keith Lyston, 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 information to:

Name: Phone Number: Date of Birth:

_____
_____
_____
_____
_____
_____

By signing this waiver, I authorize Lakepointe Vision Center to release my private medical information to the above listed individuals. I understand that this authorization will not expire, unless I otherwise specify. I understand that I have the right to withdraw this authorization at any time by providing Lakepointe Vision Center with a written and dated notice. Any release of information made prior to the receipt of the withdrawal notice will be considered in compliance with this release. I also understand that once released, the information will no longer be protected by federal privacy regulations.

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Signature of Patient / Guardian Date Signature of Witness Date

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Relationship to Patient