Simply the Best
Daynes
EyeCare

Authorization to Release

Patient Name: _____ DOB:_____

I hereby authorize the individual(s) listed below to be able to:

*Pick up Glasses/ Contact Lenses, *Printed Spectacle RX/ Contact Lens RX
*Clinical Records *Medication RX
*Schedule and Inquire about appointments

Authorized Persons:

1. _____
2. _____
3. _____

I understand that:

*This authorization will be effective as long as I am a patient of Daynes Optical.
*I may revoke this authorization at any time by submitting a written notice to Daynes Optical
*Once Daynes Optical has disclosed my health information to the recipient, we cannot guarantee that the recipient will not disclose my health information.

_____
Signature of Patient or Authorized Representative

Date: _____

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REVOCATION OF PRIOR CONSENT:I wish to rescind or stop the above authorizations.

_____
Signature of Patient or Authorized Representative

Date: _____