Abilene Advanced Eyecare & Vintage Eyewear

Authorization of Release of Medical Information

Acknowledgement of Electronic Signature

By signing below, I am acknowledging acceptance of my electronic signature by device, means, or action as legally binding terms and conditions of all consents and agreements. I further agree that my electronic signature on all documents is valid as if I signed the document in writing.

Privacy regulations require us to have a release signed by our patients so we may speak with family members, friends, and other relations regarding your medical treatment and patient financial information. Each person you wish to be considered a contact must be listed individually by name (including spouse or significant other).

I hereby authorize **Abilene Advanced Eyecare & Vintage Eyewear** to release my medical information to the following:

Please Print:

1._____

Name Relationship to Patient

2._____

Name Relationship to Patient

3._____

Name Relationship to Patient

_____

Printed Name of Patient Patient's Date of Birth

_____

Patient's Signature Today's Date

_____

Guardian Signature Relationship to Patient Today's Date

This authorization will remain in effect until written notice from the patient is received cancelling the authorization of release.