Member
American Optometric Association

COASTAL FAMILY EYE CARE, L.L.C.

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TELEPHONE 207-563-3049 FAX (207) 563-3904

CONSENT FOR RELEASE OF INFORMATION

TO: _____
_____
_____

I, _____, Hereby request that you release to:

Coastal Family Eye Care, L.L.C., my treatment records or a report of my diagnosis, treatment, prognosis and recommendations, contact lens specifications, as well as other data pertinent to your treatment of me.

Date of Request: _____ Date of Appointment Here:_____

Name of Patient (s) _____
_____
_____

Date of Birth (s): _____

I understand that:

I can revoke all or part of this authorization at any time by notifying Coastal Family Eye Care, L.L.C. in writing, subject to the rights of anyone who received or disclosed information prior to receiving my revocation.

I can refuse to disclose all or some of the information in my treatment records.

A refusal or revocation to release some or all information may result in improper diagnosis or treatment, denial of insurance coverage or claim for health benefits or other adverse consequences.

I can have a copy of this form upon request.

I can cross out any provision on this form with which I disagree.

Signature of Patient or Guardian:

_____

Witness: _____