LOUISIANA FAMILY EYECARE

1431 Ochsner Blvd. Ste. A ~ Covington, LA 70433 ~ PH: (985) 875-7898 ~ FAX: (985) 875-9844

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

IMPORTANT: This form authorizes your health care provider to release health information regarding your care and/or treatment to the individual or organization you identify as set out below. Your signature on this form indicates that you are giving permission for the disclosure of you health information.

Patient's Name: _____

Address: _____

Date of Birth: _____ **Phone Number: _____**

I authorize information to be released from:

☐ **Louisiana Family Eyecare**
1431 Ochsner Blvd. Ste. A
Covington, LA 70433
PH: (985) 875-7898
Fax: (985) 875-9844

☐ _____
_____
_____

Please release the following:

____ All Records **____ Eyeglasses Rx** **____ Clinic Notes**
____ Contact Lens Rx **____ Other:**

Please send the records to:

☐ **Louisiana Family Eyecare**
1431 Ochsner Blvd. Ste. A
Covington, LA 70433
PH: (985) 875-7898
Fax: (985) 875-9844

☐ _____
_____
_____

I, hereby authorize you to disclose the information listed above. I understand that this authorization is voluntary. I understand that I am under no obligation to sign this authorization.

_____ _____
Signature of Patient or Patient's Representative **Date**

_____ _____
Printed Name of Representative (if applicable) **Relationship to Patient**

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