DISCLOSURE OF HEALTH CARE INFORMATION

NAME: _____

DATE OF BIRTH _____

DATE: _____

I hereby request Coastal Family Eye Care, L.L.C. release my records to:

_____

Information to be released: total record or date to and from _____

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that uses and disclosures already made cannot be taken back. To revoke this authorization, I must do so in writing and send it to Coastal Family Eye Care L.L.C. 5 Edward Avenue Damariscotta Me 04543-4252. This authorization expires 30 months from date of this authorization unless I revoke it earlier.

_____
Signature of Patient or Legal Guardian

_____
Printed Name

_____
Witness

_____
Witness Printed Name