COASTAL FAMILY EYE CARE, L.L.C.

5 EDWARD AVENUE DAMARISCOTTA, MAINE 04543-4252 TELEPHONE 207-563-3049 FAX 207-563-3904

CONSENT FOR RELEASE OF INFORMATION

To: _____

_____

_____

I, _____, hereby request that you release records to: Coastal Family Eye Care, LLC. Please include treatment records, reports of my diagnosis, treatment, prognosis, and recommendations. Contact Lens specifications, as well as other data pertinent to my treatment of care.

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 in writing, subject to the rights of anyone who received or disclose information prior to receiving my revocation. I may refuse to disclose all or some of the information in my patient records. A refusal or revocation to release some or all the 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 any time upon request and can cross out any provision on this form with which I disagree.

Signature of Patient or Gaurdian: _____