Release of Information

I, _____ authorize Blue River Vision to disclose the following (check all that apply):

- Pick-up of glasses and/or contact lenses
- Diagnosis and results of examination
- Copy of medical records
- Account or financial information
- Other (be specific): _____

To the individuals listed below (please provide address or fax if another medical doctor):

_____

_____

_____

_____

_____

I understand that:

- ✓ This authorization to release information will remain in effect until I revoke it in writing
- ✓ This consent does not permit the recipient to authorize release of my information to a third party
- ✓ This is a standing consent and will not result in the release of information unless requested by the recipient listed above.

_____ _____

Signature **Date**

_____

Printed Name