Medical Information Release

An authorization is legally required for us to release any information regarding your care.

1- What Eye Information Are You Requesting?

_____

2- What is the USPS mailing address to send this information? Print clearly please.

NAME: _____

ADDRESS _____

CITY _____

STATE/ ZIP _____

I authorize my information to be released for the purpose of my care. I understand that my health information may not be used or shared in other ways unless I give another authorization, or unless that use is specifically allowed by law. California recipients are required to obtain your authorization before further disclosing this information. San Anselmo Optometry is released from any legal liability for disclosing my health information to the extent they are authorized. I understand that a copy of this original is as valid as the original.

_____ _____

SIGNATURE of Patient/Parent/Guardian or Authorized Representative Date

_____ (_____)_____-_____

PRINT NAME PHONE

Please send this completed form to:

San Anselmo Optometry
634 San Anselmo Ave
San Anselmo, CA 94960

Or email to : eyes@sao2020.com