AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patients Name: _____

Address: _____

_____

Date of Birth: _____

Release Information To:

RHODE EYELAND, LLC
JACQUELINE BOISVERT, OD
74 FRENCHTOWN ROAD
NORTH KINGSTOWN, RI 02852
(T) 401-262-0042 (F) 401-262-0140

Information Requested From:

_____
_____
_____

This request and authorization applies to: *(Please initial all that applies)*

_____ Eyeglass and Contact Lens Prescription

_____ Medical Health Record

_____ Specialized Testing and Photos

THIS AUTHORIZATION EXPIRES IN NINETY (90) DAYS

Patient Signature: _____ Date Signed: _____

Witness Signature: _____ Date Signed: _____