ROCHELLE EYE CARE CENTER

PATIENT AUTHORIZATION FORM

I do hereby authorize the Rochelle Eye Care Center to use or disclose my optical, medical and billing information to the following individuals in addition to my doctors and insurance company.

Authorized individuals:

NAME: _____ RELATIONSHIP: _____
NAME: _____ RELATIONSHIP: _____
NAME: _____ RELATIONSHIP: _____
NAME: _____ RELATIONSHIP: _____
NAME: _____ RELATIONSHIP: _____
NAME: _____ RELATIONSHIP: _____

PLEASE NOTE: if an individual=s name is NOT on this list, we will not disclose any information regarding your health, visual status, account or personal information, NOR will we dispense your glasses or contacts to that individual.

If you think you will ever send someone in to the office to pick up an order etc., we will need to have that person=s name on this list. Otherwise they are not authorized to be involved with your eye health care.

You have the right to amend this authorization at any time. However, until this change is submitted in writing with your signature, this authorization will remain in effect.

_____
Print patient=s name

_____ _____
Patient=s/Guardian=s Signature Date

_____ _____
Print name of Guardian Relationship