LYNN EYE MEDICAL GROUP

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Name: _____ Date of Birth: _____/_____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis and the records of any treatment or examination rendered to me. This information may be released to:

_____ [ ] Spouse _____
Name

_____ [ ] Child(ren) _____
Name

_____ [ ] Other _____
Name

[ ] Information is not to be released to anyone.

Messages

Please call [ ] my home [ ] my work [ ] my cell [ ] _____

If unable to reach me [ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] _____

The best time to reach me is _____ between _____
day(s) *time*

Signed: _____ Date: _____/_____/_____
Patient's signature

Witness: _____ Date: _____/_____/_____
LEMG employee

Thank you for filling out this form completely. The information you have provided will help us serve your healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask. We will be happy to help you.

Rev. 10/12/2010