PATIENT AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I ____ hereby request and authorize
(Patient or Guardian Name)
____ to disclose and provide copies
(Center Name)

of any and all clinical treatment records and information concerning my care, which is in the possession of this person or entity, to:

____
(Name of provider, optometrist, specialist, consultant, patient attorney, insurer, etc.)

____

(Address)
____

(City) (Province)
____
(Telephone)

or ***office stamp*** below:

These records include, but are not limited to: personal patient information, medical histories, examination records, clinical photographs, treatment plans, treatment records, referral and consultation recommendations and reports, diagnostic models, and other related materials.

I expressly release from liability University Optometric Clinic, from any and all liability arising from compliance with this request and disclosure of the requested information.

Signed: ______________________________________ Date: _____________________
(Patient or Guardian Signature)

PLEASE FAX THIS COMPLETED FORM BACK TO (416) 977-2604