



**AUTHORIZATION FOR AND CONSENT TO
RELEASE INFORMATION**

I, the undersigned patient/guardian, hereby authorize _____ to release information listed below from the records of _____, date of birth _____, to be released to EYE1ST VISION & LASER.

The release of information to which I consent is for the purpose of: _____

For the following dates of hospitalization or outpatient services: _____

I understand this authorization includes release of all medical records including HIV records, Psychiatric/Mental Illness, Drug/Alcohol abuse records, Venereal Disease and any other statutory protected diseases. This authorization and consent will expire ninety (90) days following the date signed. I understand that I may revoke this authorization and consent at any time except to the extent that action has previously taken in reliance hereof.

Signature of Patient/Guardian

Date of Signature

Relationship to Patient

Signature of Witness

Please fax this form to: **(770) 623-3937** (no cover sheet required)

Or mail to: **Eye1st Vision & Laser
10080 Medlock Bridge Rd
Duluth, GA 30097**