Clark | Tait
EYE CENTER
Keeping You In Focus

RELEASE OF MEDICAL INFORMATION

I, the undersigned, hereby authorize release of any or all medical information to the following individuals. This is for family members or friends that have my permission to call or pick up medical information or test results on my behalf.

	Name	**Relationship**	**Phone number**
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

_____ _____

Patient Signature **Date**