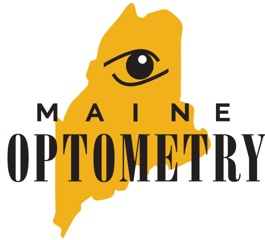

Brunswick • Freeport • Gorham • Lewiston
Lisbon Falls • Saco • Standish • Windham

207-729-8474

See the Difference
MAINEOPTOMETRY.COM

Authorization to Release or Obtain Healthcare Information

PATIENT NAME: ______________________________ DOB: ______________

RESPONSIBLE PARTY: ______________________ RELATIONSHIP TO PATIENT: ______________

RELEASE RECORDS TO:	RELEASE RECORDS FROM:
PHYSICIAN/INSTITUTION:	PHYSICIAN/INSTITUTION:
ADDRESS:	ADDRESS:
CITY, STATE, ZIP:	CITY, STATE, ZIP:
PHONE:	PHONE:
FAX:	FAX:

This request and authorization applies to (check all that apply):

- ☐ All health information: ______________________________
- ☐ Specific health information relating to the following treatment, condition or dates:

____

- ☐ Other: ____

____

____ DATE: ______________

Doctor Reviewed/Approved

____ DATE: ______________

Patient/Parent/Legal Representative Signature

This authorization is valid for 90 days from the date of signature.