AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT NAME _____ DATE OF BIRTH: _____

PATIENT'S ADDESS _____

PATIENT'S PHONE NUMBER _____

I hereby authorize the release of my medical records, or copies of such

FROM the office of:

DOCTOR/CLINIC/HOSPITAL NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

TO the office of Through the Hayes Optometry, Inc

Drs. Therese Langille and Angela Tam

529 Hayes St., San Francisco, CA 94102

415.553.6166 phone/**415.553.6168 FAX**

Specifically I would like the following data released:

( ) Last spectacle parameters, including lens type

( ) Last contact lens parameters, including date dispensed and expiration date

( ) All eye exam data, including photos and/or visual fields

( ) Other: _____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

PATIENT'S SIGNATURE: _____ DATE _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

REPRESENTATIVE'S NAME _____ RELATIONSHIP TO PATIENT _____

SOURCE OF AUTHORITY _____