DISCLOSURE OF HEALTH CARE INFORMATION

NAME: ______________________________
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DATE OF BIRTH ______________________________
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DATE:______________

I hereby request McCormick and Bouchard Eye Care, L.L.C. release my records to:

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Information to be released: total record or date to and from______________

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that uses and disclosures already made cannot be taken back. To revoke this authorization, I must do so in writing and send it to McCormick and Bouchard Eye Care L.L.C. 5 Edward Avenue Damariscotta Me 04543-4252. This authorization expires 30 months from date of this authorization unless I revoke it earlier.

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Signature of Patient or Legal Guardian

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Printed Name

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Witness

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Witness Printed Name

Scanned with CamScanner