advancedeyecenter
INNOVATIVE VISION IMPROVEMENT

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Date_____

To: _____

Fax Number: _____

From: Dr. Susan Jong, O.D.
5151 Bluebonnet Blvd
Baton Rouge, LA 70809
Phone: 225.769.6010
Fax Number: 225.769.6098

Patient Name: _____ Date of Birth: _____

I request the release of the following medical information to Dr. Susan Jong.

_____My medical record.
_____My most recent contact lens Rx, including lens manufacturer and lens design information, Rx date and date of last contact lens visit if applicable.
_____My most recent dated spectacle Rx.
_____Other: _____

Patient Signature: _____ Date: _____

*If the patient is not yet eighteen (18) years old, the child's parent or guardian must complete and sign the following form:

I, _____, hereby warrant that I am the Parent/Guardian of the patient listed above and have full authority to authorize the above release form which I have read and approved. I hereby release medical records for the patient listed above to Advanced Eye Center.

Parent/Guardian Signature: _____ Date: _____