TREASURE STATE
EYE CARE

Medical Information Release Form

Health Insurance Portability and Accountability Act (HIPAA) Release

Patient Name: ______________________ DOB: ____/____/________

Please select one of the following:

[ ] I authorize the release of my eyeglass prescription, contact lens prescription, claims information, and also the pick up of my eyeglasses and/or contact lens products. Please list below anyone you may want us to release this information/products to:

____

____

____

[ ] Information is not to be released to anyone

This Medical Information Release Form will remain in effect until the patient terminates in writing to Treasure State Eye Care

In case of an **Emergency**, please call:

Name: ____________________________ Phone Number: (_____)________________

Signed: __________________________ Date: ____/____/________