BLINK VISION
BY VEATCH

RELEASE OF INFORMATION

Authorization For Use/Disclosure Of Health Information

Name Date of Birth

_____ Dr. Ryan Veatch

Authorization for Use/Disclosure of Information: I voluntarily authorize and direct my vision care provider **Blink Vision By Veatch** to discuss my vision records/information with the individual that I have identified below.

Recipient: Name of person or class of persons to whom my vision care provider may disclose my vision information to:

Name(s):

Address:

Phone: Email:

Relationship to Patient:

Purpose: I understand that the specific purpose of the authorization is at the request of the patient.

Information to be disclosed: This authorization permits the above provider **Blink Vision by Veatch** to disclose all of my health information that the provider has in his or her possession, including information relating to any medical history, vision history, mental or physical condition and any treatment received by me.

Signature Date