ADELSON
EYE & LASER CENTER

MEDICAL INFORMATION RELEASE AUTHORIZATION

I hereby authorize Dr. Adelson to discuss with and/or release any information to the following person(s). If you want your spouse to have access to this medical information, the name must also be listed below. Also, children 18 years or older must give permission for their parents to have access to their medical information.

I, _____ give permission to the physicians and staff at Adelson Eye & Laser Center to discuss any medical information with the following person(s):

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

This permission includes discussing results of examinations, x-ray and laboratory findings, future testing to be scheduled and information pertaining to insurance billing. I also give my permission to allow the above named individual(s) to sign for and receive copies of any and all medical records.

Do you give permission to Adelson Eye & Laser Center to leave a message on your voicemail in the event we cannot get a hold of you?

❑ Yes ❑ No | Phone Number _____

_____ _____
Patient Signature (or person authorized) Date

_____ _____
Witness Date