

**AUTHORIZATION FOR RELEASE OF  
PATIENT INFORMATION**

Patient/Client Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**This is authorization to:** \_\_\_\_\_  
*(Name of Medical Practitioner/Optometrlist/Optician)*

**To immediately release my optical prescription and any other relevant information to:**

Name of Optician to receive information: \_\_\_\_\_

Fax Number of Optician: \_\_\_\_\_

I release the above noted physician/medical practitioner/optician, their employees and agents, from any and all claims whatsoever which may arise as a result of the release of the above information.

\_\_\_\_\_  
*(Signature of Patient)*

\_\_\_\_\_  
*(Date)*