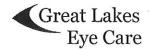
2848 Niles Rd. St. Joseph, MI 49085 Phone: (269) 428-3300 Fax: (269) 428-5005 120 Longmeadow Village Dr. Niles, MI 49120 Phone: (269) 684-6400 Fax: (269) 684-5103 570 Broadway Street South Haven, MI 49090 Phone: (269) 637-3101 Fax: (269) 637-4000 3550 Park Place West #200 Mishawaka, IN 46545 Phone: (574) 222-1403 Fax: (574) 387-5464



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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION OF

The following will be completed by the patient or the patient?	s authorized representative
Patient Name: (Please Print) DOB	Telephone:
I hereby authorize:	
Name of provider who is to release information	
Address of provider who is to release informatio	n
To release the following protected health information contained in my med treatment between the following dates: to	
Name of provider who is to receive information	
Address of provider who is to receive information	Fax number of provider receiving information
Authorization is for the use and disclosure of the following records: (plate Doctor examination notes Other: (specify)	
 My authorization is given freely with the understanding that: I may refuse to sign this authorization. I may revoke this authorization at any time, except where information has my authorization, provided that my revocation is in writing. Great Lakes Eye Care may not condition my treatment on my provision. A photocopy or fax of this authorization is as valid as the original. Great Lakes Eye Care, its directors, officers, employees, agents and vollegal responsibility or liability for disclosure of the above information therein. Upon my request I will be given a copy of this signed authorization if the Great Lakes Eye Care. This authorization is valid for one year or the following period of time: 	of this authorization. unteers are hereby released from any of the extent indicated and authorized the authorization is at the request of
Signature of Patient or Legal Representative	Date
Printed Name of Above If the above signed is not the patient please indicate the relationship to the patient	For Great Lakes Eye Care use only REQUESTED RELEASED Faxed □ Faxed □ Mailed □ Mailed □ Picked-up □ Date: Date: Emp: