



## Authorization for Release of Medical Information

\_\_\_\_\_  
Patient Name

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

\_\_\_\_\_  
Social Security Number

I hereby authorize:

\_\_\_\_\_  
Doctor / Medical Group / Hospital / etc

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
Phone

To release the following information to:

**Lakepointe Vision Center  
Dr. David S. Eghigian  
1003 E. Wesley Dr. Ste A  
O'Fallon, IL 62269  
Ph: (618) 624-3937  
Fax: (618) 624-3940**

Information to be released:

- All Medical Records
- Current Prescription for Glasses and / or Contact Lenses
- Last Comprehensive Examination Record
- Other Specific Information

(explain) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

By signing this waiver, I authorize release of private medical information to Lakepointe Vision Center, as stated above. I understand that this authorization expires in six months from the date of signature, unless I otherwise specify or revoke the authorization. I understand that I have the right to withdraw this authorization at any time by providing Lakepointe Vision Center and the above mentioned party with a written and dated notice. Any release of information made prior to the receipt of the withdrawal notice will be considered in compliance with this release. I also understand that the party releasing my medical information may require further documentation before complying with my request.

\_\_\_\_\_  
Signature of Patient / Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient