SAKOWITZ EYE CENTER
2850 WELLNESS AVE
ORANGE CITY, FL 32763
(386) 574-0700

PATIENT AUTHORIZATION TO DISCLOSE INFORMATION

PATIENT NAME _____

I GIVE PERMISSION TO SAKOWITZ EYE CENTER TO RELEASE ANY OF MY PERSONAL HEALTH INFORMATION, INCLUDING ANY MEDICAL INFORMATION IN MY CHART TO:

1. NAME _____ PHONE NUMBER _____

   RELATIONSHIP TO PATIENT_____
2. NAME _____ PHONE NUMBER _____

   RELATIONSHIP TO PATIENT_____
3. NAME _____ PHONE NUMBER _____

   RELATIONSHIP TO PATIENT_____
4. NAME _____ PHONE NUMBER _____

   RELATIONSHIP TO PATIENT_____
5. NAME _____ PHONE NUMBER _____

   RELATIONSHIP TO PATIENT_____
6. NAME _____ PHONE NUMBER _____

   RELATIONSHIP TO PATIENT_____
7. NAME _____ PHONE NUMBER _____

   RELATIONSHIP TO PATIENT_____
8. NAME _____ PHONE NUMBER _____

   RELATIONSHIP TO PATIENT_____

SIGNATURE _____ DATE _____