AUTHORIZATION FOR RELEASE OF INFORMATION

Date:_____

Patient Name:_____DOB:_____

I hereby freely authorize _____ to release my medical records and related information contained therein. This information is released for the purpose of:

_____

_____

I authorize the custodian of records or other person/entity (specifically describe) to disclose/release the requested information. I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information. Please send the records to:

20/20 Vision Express

John L. Mari OD, Jordan D. Mari OD, AJ Motacek OD

1300 Gateway Dr S Info@2020visionexpress.com

Fargo ND 58103 Phone 701-235-0280 Fax 701-235-3326

_____ _____

Patient Signature Date

_____ _____

Witness Responsible Party when necessary