

Authorization to Disclose Spectacle Prescription

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ E-Mail: _____

Date of Birth: ____/____/____ Soc. Sec. Number: ____-____-____

This information may be disclosed to and used by:

Eye Lab Rx
918 Mansfield Dr.
Fort Collins CO 80525

for the sole purpose of fabricating my spectacle prescription.

I understand that the information released is for the specific purpose stated above. Any other use of this information without written consent of the patient is expressly prohibited.

The prescription may be transmitted via:

FAX: 206-337-1379
VOICE MAIL: 970-430-2006

TO BE COMPLETED BY PRACTITIONER:

	Sphere	Cylinder	Axis	Prism	Rx Date: ____/____/____
R:	_____	_____	_____	_____	Expires: ____/____/____
L:	_____	_____	_____	_____	
ADD: R:	_____	L: _____		PD: DISTANCE: R: _____ L: _____	
				NEAR: R: _____ L: _____	

Practitioner's Name: _____

Name of Business: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ E-Mail: _____

SIGNATURE OR LEGAL REPRESENTATIVE

DATE

PRACTITIONER'S SIGNATURE

DATE

RELATIONSHIP TO PATIENT