Bruening
EYE SPECIALISTS

Due to HIPAA regulations we are required to get your authorization before releasing any information to anyone regardless of the relationship to you.

I _____ give consent for you to release my medical information to the following people.

Name:_____

Relationship:_____

Name:_____

Relationship:_____

Name:_____

Relationship:_____

Name:_____

Relationship:_____

Signature:_____ Date:_____