# LYNN EYE MEDICAL GROUP

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Name: _____ Date of Birth: _____/_____/_____

## ***Release of Information***

[ ] I authorize the release of information including the diagnosis and the records of any treatment or examination rendered to me. This information may be released to:

_____ [ ] Spouse _____
*Name*

_____ [ ] Child(ren) _____
*Name*

_____ [ ] Other _____
*Name*

[ ] Information is not to be released to anyone.

## ***Messages***

Please call [ ] my home [ ] my work [ ] my cell [ ] _____

If unable to reach me [ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] _____

The best time to reach me is _____ between _____
*day(s)* *time*

Signed: _____ Date: _____/_____/_____
*Patient's signature*

Witness: _____ Date: _____/_____/_____
*LEMG employee*

*Thank you for filling out this form completely. The information you have provided will help us serve your healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask. We will be happy to help you.*

*Rev. 10/12/2010*