Permission for Release of Medical Information

This authorization will be effective from the date of signature until it is revoked by the patient.

☐ I authorize Ventura Eye Institute to give medical information regarding the following specific condition(s):

☐ All Information ☐ Surgeries & Instructions

☐ Procedures & All Test Results ☐ Treatment Information

☐ Medication Information & Refills ☐ Appointment Information

To: _____ who is related to
(person)
me as my: _____. I release Ventura Eye Institute from any liability resulting from the release of this confidential information.

☐ **I DO NOT authorize Ventura Eye Institute to release ANY medical or appointment information to anyone besides myself.**

OPTIONAL -

☐ I authorize Ventura Eye Institute to leave a detailed message of any medical testing results or medications on my answering machine if I am not home.

_____ _____
Patient's Signature Date

_____ _____
Witness Signature Date

_____
Patient Name DOB