Authorization to Disclose Information

I authorize Werner Optometry, A.P.C. to disclose my information to a third party recipient or myself as I designate below:

- ❑ SELF *Authorized to send requested information via mail, fax and/or email*
- ❑ SPOUSE _____
  Print Name of Spouse
- ❑ PARENT _____
  Print Name of Parent / Guardian
- ❑ OTHER _____
  Print Name and Relationship

INFORMATION THAT CAN BE DISCLOSED:

- ❑ All pertinent records in your possession concerning my illness and / or treatment, including copies of prescriptions on file.
- ❑ Financial information related to payments and/or insurance claims.

I understand that I can revoke this authorization at any time.

_____ _____
Print Name of Patient *Patient Date of Birth*

_____ _____
Signature (Patient, Parent or Guardian) *Today's Date*