Hampton Eyecare Associates, PLLC

760 Lafayette Road • Hampton, NH 03842
Phone: 603-926-5471 | Fax: 603-926-9546

Patient's Authorization to Disclose Health Information

Patient Information

Patient Name:

DOB:

Address:

Patient Phone Number:

Release of Records

I hereby authorize Hampton Eyecare Associates, PLLC to:

☐ ■ Release Records To ☐ ■ Obtain Records From

Facility/Doctor Name:

Address:

Phone: Fax:

Type of Records Requested (Select all that apply):

☐ Complete medical record, including results of diagnostic testing
☐ Copy of spectacle prescription
☐ Copy of contact lens prescription
☐ Other (specify):

Method of Delivery:

☐ Fax ☐ Mail to address listed abov ☐ Electronic (portal or direct)

Authorization & Signature

I have read and understand this form.
I voluntarily authorize the disclosure of my health information as described in this form.
If I am signing for a minor, my signature attests that I have legal authority over medical decisions for the designated minor..

Patient/Legal Guardian Name:

Relationship (if not patient):

Signature: Date: