Medical Consent Authorization to

Eyes in Sight

9191 Kyser Way #600

(214) 705-9433

Fax: (214) 705-9318

Name:

DOB:

Phone:

I hereby authorize the Eyes in Sight to: _ release _ obtain _ discuss

from:

I have read and understand this authorization. I expressly and voluntarily consent to disclose the above information to the persons / agencies named above. I release Eyes in Sight from all legal responsibility that may arise from the release of these medical records. A photocopy of the consent shall be as valid as the original. This authorization will remain in effect for one year unless specifically revoked in writing.

Patient Signature _____

Date _____