Authorization for Release of Information

1. I (undersigned) authorize David Grisham, O.D.

615 "B" Street STE #2 San Rafael, CA 94901 (415)459-2020

(Stree) (City/ State} (Phone Number)

To release information from the record{s} of : _____
(patient Last Name) (first Name) (middle)

Covering the period(s) of treatment:

2. Information to be released:

All RECORDS _____

3. Information is to released to:

4. A photocopy of this authorization is to be considered as valid as the original.

5. I understand that the information used or disclosed pursuant to this authorizaion may be subject to re-disclosure by the receipient and mat no longer be protected by Federal Law.

SIGNATURE: _____ DATE: _____

PRINT NAME_____

Relationhip to personal/legal representative signing for patient_____