PERSONAL REPRESENTATIVE AUTHORIZATION FOR MEDICAL RELEASE FORM

I authorize John Hadlock, BCO, Eye Concern, Inc. and staff to speak to the following family members or my personal representative regarding:

☐ All medical information, including but not limited to records pertaining to examinations, treatments, consultations, billing records, x-rays and reports, history, laboratory findings, admissions and discharge reports, treatment records, diagnosis and prognosis and records, nurse's and doctor's notes, and any other non-medical information in my file.

☐ Only the following types of information:

_____

_____

The above medical information shall only be released to the following persons:

Family Member / Personal Representative	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

I understand that I may terminate this Medical Authorization form. I must notify John Hadlock, BCO, Eye Concern, Inc. in writing regarding termination and effective date.

This authorization shall remain valid (check one):

☐ Until revoked in writing.

☐ Until _____ , 20____

I know that I am entitled to receive a copy of this agreement.

Signed this _____ day of _____, 20_____, at _____, AZ

Sign_____

Print_____