

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I, \_\_\_\_\_, hereby request the disclosure of information from my record.  
(Name of Patient)

Patient Identification: Address: \_\_\_\_\_  
City/ State: \_\_\_\_\_  
Phone: \_\_\_\_\_ Date of birth: \_\_\_\_\_

The information is to be released FROM:

Person/ organization. Facility Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/ State: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_

The information is to be released TO: **ADVANCED FAMILY EYECARE**  
Vision Source  
Jennifer L. Brooks, O.D.  
Matthew P. Brooks, O.D.  
Samuel C. Oliphant, O.D., F.A.A.O  
14000 Quailbrook Dr.  
Oklahoma City, OK 73134  
405-751-7727 Fax 405-755-1875

The information to be released is as follows:

- Any information contained in the patient's record
- Only information related to (specify)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate on the date I have indicated.

Termination Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date \_\_\_\_\_

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The information is to be released **TO:**  
Person/ organization. Facility Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/ State: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_

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