Authorization to Release Patient Information:

I, _____, hereby authorize Southern Eye Associates to discuss any of my medical information with the following people that may be involved with my care.

1. Name: _____

   Date of Birth: _____

   Relationship to Patient: _____

   Phone Number: _____

2. Name: _____

   Date of Birth: _____

   Relationship to Patient: _____

   Phone Number: _____

3. Name: _____

   Date of Birth: _____

   Relationship to Patient: _____

   Phone Number: _____

***Patient Signature: _____**

***Patient DOB: _____**