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Authorization for Medical Information Release

This release authorization permits Craig G. Hoover, O.D. and Associates, PLLC to obtain / release copies of all medical records involved in the care and treatment of: (circle one)

Patient name: _____

First name Middle name Last name

Social Security Number: __ __ __ - __ __ - __ __ __ __

Date of Birth: _____ / _____ / _____

Month Day Year

I hereby release: _____

_____

_____

From any law related to disclosure of confidential or privileged information. I agree that a photocopy of this authorization has the same authority as the original.

Signature: _____ **Date:** _____

Parent or Guardian: _____ **Date:** _____

Witness: _____