Consent for Release of Medical Information

Shores Optometry East
3923 Pine Grove Road
Fort Gratiot, MI 48059

Patient name:_____

Date of birth:_____Phone number:_____

Address:_____

City:_____State/Zip Code:_____

Protected health information to be disclosed:

If you consent to all personal and medical information being shared, you may select the following:

- ☐ Any and all records

If you only would like some of your information to be disclosed, you may choose one of the following:

- ☐ Eyeglass and/or Contact Prescription
- ☐ Medical Information, including appointment dates and times
- ☐ Billing Matters
- ☐ Address/phone number(s)

Name of person/organization that your information may be disclosed to:

- ☐ Family member:_____
  _____
- ☐ Friend:_____
  _____
- ☐ Doctor/Healthcare provider:_____
  _____
- ☐ Other: _____
  _____

Patient Signature:_____ Date:_____