Consent To Release Information

Patient Name:_____ Birth Date:_____

I, the undersigned, hereby authorize the physician listed here:

Highlands Eyecare
4500 W. 38th Avenue;
Suite 130, Bldg J
Denver, CO 80212
Phone: 303.455.0888
Fax: 303.455.0300

To release medical information concerning the above named patient to:

_____
_____
_____
_____

This medical information will include copies of all office visits, visual fields, lab reports, discharge summaries, and all correspondence pertaining to the patient's evaluation and treatment.

X_____ Date:_____
Signature of Patient or Legal Guardian

_____
Relationship, if not the patient