

AUTHORIZATION FOR DISCLOSURE

I, _____, hereby authorize Central Pennsylvania Eye Institute to disclose medical information regarding my treatment to the following person(s):

- | | | |
|--------------|------------------------|----------------------|
| ___ Parents | ___ Grandparents | ___ Guardian |
| ___ POA | ___ Siblings | ___ Aunt(s)/Uncle(s) |
| ___ Children | ___ Niece(s)/Nephew(s) | ___ Spouse |
| ___ *Other | ___ Life Partner | |

Please provide Name(s) of person(s) authorized:

***Other – Please provide name of person and/or facility and/or title:**

Date

Patient Signature