ILLINOIS eye CENTER
Your Vision Empowered

Patient Name _____

DOB _____

Account No. _____

I hereby authorize Illinois Eye Center to release information regarding my protected health information to the following persons and/or agency. I also understand if there is a change in the information given below, I must notify the Illinois Eye Center in writing. This authorization can be revoked at anytime with my written permission.

Signature_____ Date_____

NAME/AGENCY	RELATIONSHIP
1.)_____	_____
2.)_____	_____
3.)_____	_____
4.)_____	_____
5.)_____	_____