Shared Release

Section I

Patient Name_____ DOB_____

A. ____I give my permission for the following information to be shared with the following individuals. I understand this release is valid for 2 years from today's date. I can SHORTEN the length of this release, but I cannot extend it. **(MUST FILL OUT SECTION II)**

ONLY fill in date if less than 2 years from today: _____

Patient Signature:_____
(Parent or Guardian if a minor)

As a parent or guardian, I understand that this shared release is no longer if the individuals turns 18 years of age within the 2 year period.

OR

B. _____I DO NOT give permission for anyone to have access to any of my information.

Patient Signature:_____
(Parent or Guardian if a minor)

Section II

A. Information to be shared. Please check all that apply.
   a. ____Medical Records Only
   b. ____Billing Information Only
   c. ____Glasses and/or Contact prescriptions
   d. ____ALL of the above

B. Who can have access to the above information.
   a. _____

   b._____

   c._____

   d._____

   e._____