Thompson Rivers Family Optometry

Dr. Robert J. ALLAWAY* & Associates
Optometrists

- [ ] I authorize **NO ONE**, aside from myself, to hear or receive any of my medical information or prescriptions unless I provide a one time written permission.

- [ ] I authorize **NO ONE**, aside from myself, to pick up orders on my behalf.

This form is not consent for control of treatment. This form consents that the listed individual(s) are permitted, too; receive copies of my exams or prescriptions, receive verbal information about the health of my eyes, receive verbal information about my orders, pick up orders on my behalf. By signing this form, I authorize the release or disclosure of the protected health information (PHI) or products described above.

I have discussed any concerns I may have about the release or disclosure of my health information with the staff of Thompson Rivers Family Optometry. I understand that Thompson Rivers Family Optometry assumes no responsibility for the subsequent use/misuse by others of my health information which was disclosed under this authorization. I release Thompson Rivers Family Optometry from all legal liability that may arise from release of my information under this authorization.

The patient or their legal representative may revoke this authorization by notifying, in writing, Thompson Rivers Family Optometry.

Patient Name: ____

Patient, or guardian, Signature: __________________________

Name of Signee: ______________________________________

Date of signature: _____________________________________

THERE ARE 2 SIDES TO THIS QUESTIONNAIRE
PLEASE FILL OUT BOTH TO THE BEST OF YOUR ABILITY

Thompson Rivers Family Optometry

Releases Consent

Full Name	Relationship	Date of Birth	Contact Number/email

Full Name *Relationship* *Date of Birth* *Contact Number/email*

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