

CONEJO-SIMI EYE MEDICAL GROUP

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Name: _____ Date of Birth: ____/____/____

Release of Information

I authorize the release of information including the diagnosis and the records of any treatment or examination rendered to me. This information may be released to:

Spouse _____
Name Phone Number

Child(ren) _____
Name Phone Number

Other _____
Name Phone Number

Information is not to be released to anyone.

Messages

Please call my home my work my cell _____

If unable to reach me you may leave a detailed message
 please leave a message asking me to return your call

The best time to reach me is _____ between _____
day(s) time

Signed: _____ Date: ____/____/____
Patient's signature

Witness: _____ Date: ____/____/____
CSE employee

Thank you for filling out this form completely. The information you have provided will help us serve your healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask. We will be happy to help you.