

# 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.*