Medical Release Consent Form

I, _____, give my consent for my medical history as recorded by **Effingham Eye Care**, including contact lens and spectacle prescriptions, to be provided to the following people:

Name:	Relationship:	Permission to Pick-Up or Order Contacts/Glasses? Y/N

I acknowledge that this consent is granted until such time as I withdraw such consent and I understand that I have the right to obtain access to my medical records from **Effingham Eye Care**.

***Please note: If you wish to release any of the above mentioned information or allow someone to pick-up on your behalf that is not listed above you will need to call to give verbal consent.*

Signature: _____ Date: _____