Patient Information Release Form

Please Select One:

- I do **not** want any information about my eye care communicated to family members/caregivers.
- I give Beacon Eye Care permission to verbally communicate to family members/caregivers listed below.

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

This authorization does not expire unless revoked by patient.

Patient Signature_____ Date_____