WILLIAMSBURG
Eye Care
Drs. Lundberg & Lodwick, Optometrists

Authorization for Release of Personal Health Information

I, _____, authorize the release of all my personal health information from the office of Pamela D. Lundberg, O.D. and Richard K. Lodwick, O.D. to the following entities:

_____ _____

_____ _____

_____ _____

(Include family or friends to whom releases may be made)

As the person signing this consent, I understand that I am giving my permission to the above-named third party for release of confidential health care records. A copy of this consent and a notation concerning the persons or agencies to which release was made shall be included with my complete record. The person who receives the records to which this consent pertains may not re-release them to anyone else without my separate written consent unless such recipient is a provider who makes a release permitted by law. I further understand that I have the right to revoke this consent by a signed, written request.

This consent expires on ____/____/____ or INDEFINITELY

Signature:_____ Date: _____

Acknowledgment of receipt/review of Drs. Pamela D. Lundberg and Richard K. Lodwick, Optometrists' Notice of Privacy Practices

I acknowledge that I have received/reviewed a copy of Drs. Pamela D. Lundberg and Richard K. Lodwick, Optometrists' Notice of Privacy Practices.

Signature:_____ Date: _____