Dr. Wills Vanray, OD | Dr. Melissa Vanray, OD
Phone: (970) 468-0389
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325 Lake Dillon Dr., Suite 104
Dillon, CO 80435

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name (Print): ___________________________ **Date of Birth**____________________________

Address: ____

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Date Records Requested: ____

I, the patient undersigned below, authorize Lake Dillon Eye Care, LLC, to release or obtain my medical information, receipts of payment or balance due, and/or other information considered under the HIPAA privacy law to be part of the Designated Record Set to or from the following contact or entity:

Name of Agency: _____________________________________ **Relationship:** _____________________________

Telephone: _____________________________________ **Fax:** _____________________________________

E-mail: _____________________________________

Address: ____

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Lake Dillon Eye Care, LLC and the recipient designated above are released and discharged from any liability, and the undersigned will hold the facility and its doctors harmless for complying with this authorization.

Patient/Guardian Signature: ______________________________ **Date:** ____________________

Notice to Person or Agency receiving this information: This information has been disclosed to you from records whose confidentiality is protected. Statutes and regulations prohibit you from making further disclosure of it without written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.