COLLEGE of OPTICIANS
OF BRITISH COLUMBIA
a B.C. Health Regulator

Print Form

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Patient/Client Name: _____

Date of Birth: _____

This is authorization to: _____
Name of Medical Practitioner/Optometrist/Optician

To immediately release my optical prescription and any other relevant information to:

Name of Optician to receive information: _____

Fax Number of Optician: _____

I release the above noted Medical Practitioner/Optometrist/Optician, their employees and agents, from any and all claims whatsoever which may arise as a result of the release of the above information.

_____
Signature of Patient

_____
Print Name of Patient

_____
Date