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

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Patient/Client Name: _____ Date of Birth:_____

I hereby authorize:

Name:_____

Business name:_____

Phone number:_____Fax number:_____

E-mail:_____

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

Name:_____

Business name:_____

Phone number:_____Fax number:_____

E-mail:_____

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 Date