COBB EYE CENTER, LLP

AUTHORIZATION TO RELEASE PRIVATE HEALTH INFORMATION

Your health information is private and confidential. Should you wish your health information shared and/or released to ***family members or friends*** who may be assisting in your care, ***please provide us with their names below:***

Name	**Relationship**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____
Patient or legally authorized signature Date

_____
Relationship to patient if signed by anyone other than patient