RAYNER EYE CLINIC, LLC
INFORMATION RELEASE AUTHORIZATION

I hereby authorize the person(s)/entities listed below to access, discuss and/or review my medical records at Rayner Eye Clinic, LLC without further authorization. Authorized persons will have complete access to my medical records including financial records. By signing below you are permitting Rayner Eye Clinic, LLC doctors and staff to discuss your medical history & financial history with such authorized persons. Any exceptions to this broad authorization should be noted beside each authorized persons name below. You may add or delete individuals on this list at any time with written notice or in person.

Authorized Individual/Entity	Exceptions	Date

PRINT Patient Name

Account #

Patients Signature

Date signed