Lilburn Eyecare & Optical Center

I, _____, give Lilburn Eyecare's doctors and staff the authorization to speak to the following people about my health information and/or my account information.

Name	Relationship	Information to Release	
_____	_____	Health	Account
_____	_____	Health	Account
_____	_____	Health	Account
_____	_____	Health	Account

Signature _____ Date _____

Without this form filled out, we will be unable to speak to anyone about your information. For minors, 17 years of age and younger, we will be able to speak to parents and names on this form.

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