CLARK EYE CENTER

RELEASE OF MEDICAL INFORMATION

I, _____, hereby authorize release of any and/or all medical information to the following individuals. This is for family members or close friends that have my permission to call and/or pick up medical information or tests.

1. _____ _____
   Name Relationship to Patient

2. _____ _____
   Name Relationship to Patient

3. _____ _____
   Name Relationship to Patient

4. _____ _____
   Name Relationship to Patient

_____ _____
Date Patient Signature

CLARK EYE CENTER 7575 W. GRAND RIVER AVENUE SUITE 111
BRIGHTON MICHIGAN 810-844-7744 FAX: 810-844-7725