KUNESH EYE CENTER, INC.

CONSENT FOR RELEASE OF MEDICAL INFORMATION TO FAMILY AND FRIENDS

May we release protected health information to a member of your family, a relative, a close friend, or any other person you identify? ❒ YES ❒ NO

Kunesh Eye Center, Inc. may release Medical Information about me to the following:

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

Do you have a Medical Power of Attorney? ❒ YES ❒ NO

If so, whom? _____

THIS CONSENT SHALL REMAIN IN EFFECT UNLESS REVOKED IN WRITING.

Signature of Patient or Personal Representative	Date
Printed Name of Patient or Personal Representative	Date of Birth
Description of Personal Representative's Authority	Patient Account #
Signature of Witness	