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
	Patient MRN