VALLEY EYECARE CENTER MEDICAL ASSOCIATES
Michael Gagnon, M.D. • Kala Swamynathan, M.D.
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Medical Information Release Form

(HIPAA Release Form)

Name: ____ Date of Birth: ____/____/____

Release of Information

[ ] I authorize the release of information including: the diagnosis, records, examination rendered to me, and claims information. This information may be released to:

[ ] Spouse: _______________________________

[ ] Child(ren): ___________________________

[ ] Other: ________________________________

This **Release of Information** will remain in effect until terminated by me in writing.

Patient Signature: _____________________________ Date: ____/____/____

Witness: _____________________________________ Date: ____/____/____

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