

**KAPPERMAN AND WHITE EYECARE**

1720 Gunbarrel Rd Ste 100

Chattanooga, TN 37421

P 423-892-2020

F 423-855-0329

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**AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION**

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Previous Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

I request and authorize \_\_\_\_\_ to  
release healthcare information for the patient named above to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates: \_\_\_\_\_

\_\_\_\_\_

All healthcare information

Other: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

**THIS AUTHORIZATION EXPIRES 90 DAYS AFTER IT IS SIGNED**