

**COBB EYE CENTER, LLP**

**AUTHORIZATION TO RELEASE PRIVATE HEALTH INFORMATION**

Your health information is private and confidential. Should you wish your health information shared and/or released to ***family members or friends*** who may be assisting in your care, ***please provide us with their names below:***

**Name**

**Relationship**

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

\_\_\_\_\_  
Patient or legally authorized signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to patient if signed by anyone other than patient