Abilene Eye Institute Cataract & Refractive Surgery Center
2120 Antilley Road
Abilene, Texas 79606

Authorization of Release of Medical Information
Acknowledgement of Review of Notice of Privacy Practices
Acknowledgement of Electronic Signature

I hereby acknowledge that Abilene Eye Institute's Notice of Privacy Practices, which explains how my medical information will be used and disclosed, has been made available to me. I understand that I am entitled to receive a copy of this document at my request.

By signing below, I am acknowledging acceptance of my electronic signature by device, means or action as legally binding terms and conditions of all consents and agreements. I further agree that my electronic signature on all documents is valid as if I signed the document in writing.

I hereby authorize **Abilene Eye institute Cataract & Refractive Surgery Center** to release my medical information to the following:

Please print

1._____
Name Relationship to patient

2._____
Name Relationship to patient

3._____
Name Relationship to patient

_____
Printed Name of Patient Patient's Date of Birth

_____
Patient's Signature Today's Date

_____
Witness/Staff Signature Today's Date

This authorization will remain in effect until written notice from the patient is received cancelling the authorization of release.