EYE ASSOCIATES OF COLUMBIA INC.

Consent For Release of Information

TO:_____

_____

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_____

I, _____, hereby authorize you to provide all records pertaining to my medical history, services rendered or treatment given to me for my contact lens and glasses prescription to:

EYE ASSOCIATES OF COLUMBIA INC.

Columbiana Grande Mall
100 Columbiana Circle
Columbia, SC 29212
Fax/Call: (803) 784-2010

Villages of Sandhills
470-5 Town Center Place
Columbia, SC 29229
Fax/Call: (803) 784-2010

You are further authorized to communicate with Eye Associates of Columbia INC either orally, via fax or in writing regarding the requested information. This consent shall be valid for thirty days from the date of signature.

_____

Signature Print Name DOB Date