Pediatric Eyecare of Western Colorado, P.C.

Deborah S. Lenahan, M.D.

Authorization to Release/Discuss Medical Information

I, ____, authorize Dr. Lenahan
(Print Patient Name)

or her designated representative to release or discuss information in my health records

to or with _________________________. I realize that I have the right to rescind
(Printed Name)

this designation at any time by contacting the staff at Pediatric EyeCare of Western

Colorado, PC.

Patient/Legal Representative: _________________________ Date_____________

Printed Name: ____________________________________ Date_____________
(if signed on behalf of the patient)

Witness:____Date_____________