PATIENT RECORDS RELEASE AND AUTHORIZATION FORM

PATIENT INFORMATION:

To Patient: After completing form, please return it to See the Sea RX via email to **Info@SeeTheSeaRx.com** or Fax to **(713) 391-8395**.

Patient Name: _____

Patient Address: _____

_____

Phone Number _____

Date of Birth _____

PROVIDER INFORMATION:

Patient Name: _____

Doctor/ Office: _____

Address: _____

Phone: _____

Fax: _____

I, the above listed patient, authorize the above listed provider to release information from my patient file, specifically my eyeglasses prescription including my recorded pupillary distance if available, to See the Sea RX via phone, fax, or email, in order for me to obtain prescription lenses for my dive mask. By initiating this request, I release the above listed provider and staff from any laws governing the disclosure of confidential or privileged information.

Patient Signature: _____ Date _____

The above listed patient is ordering prescription dive mask lenses from See The Sea RX. Please provide their prescription information to us via fax (713) 391-8395 or email: info@seethesearx.com. If you have any questions, please don't hesitate to contact us.