RELEASE OF INFORMATION TO THIRD PARTY

I authorize Belk Eye Clinic, PA (and/or all physicians and employees) to address any and/or all inquiries in

regards to my appointments, (voice / text) messages, e-mail, account activity, dispense any orders (glasses and/or contacts), and/or any medical inquiries or conditions with the following persons:

Print Name of Person	Relationship to Patient
Print Name of Person	Relationship to Patient
Print Name of Person	Relationship to Patient

Patient, Parent, or Legal Guardian Signature	**Date**	**Relationship to Patient**

AUTHORIZATION OF RELEASE FOR MEDICAL CARE

I authorize the persons below to accompany ______________________________
(Minor Child)
for appointments and give my permission for medical care to be administered and any orders to be

dispensed.

Print Name of Person	Relationship to Patient
Print Name of Person	Relationship to Patient

Patient, Parent, or Legal Guardian Signature	**Date**	**Relationship to Minor Child**