Approved Participants of Care

Patient Name: _____
Print

Medical Record Number: _____

1. _____	_____	_____	
Name (print)	relationship	telephone no.	
2. _____	_____	_____	
Name (print)	relationship	telephone no.	
3. _____	_____	_____	
Name (print)	relationship	telephone no.	
4. _____	_____	_____	
Name (print)	relationship	telephone no.	
5. _____	_____	_____	
Name (print)	relationship	telephone no.	

I authorize L.O. Eye Care to share my health information with the above named people, only as necessary, to facilitate my care. I will inform L.O. Eye Care if I ever wish to add or delete individuals from this list.

_____ _____
Patient Signature Date