Authorization Agreement

This is to advise that I have given authorization to the physicians of Fogg Remington EyeCare to provide any and all necessary information regarding my medical care to the following individuals I have identified below. This authorization is effective until terminated in writing.

Name (print)	Relationship to Patient
Name (print)	Relationship to Patient
Name (print)	Relationship to Patient

Patient Signature: _____

Parent or Guardian, if minor: _____

Date: _____