



Thames Eye Group

Your Eyes Are Our Specialty!

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HIPPA Authorization

Release of records to another provider/myself

By signing this form, I, _____, authorize the release of records from:

	Thames Eye Group, P.C.	
17 Wells Street		200 Sandy Hollow Road
Westerly, RI 02891		Mystic CT 06355
401.596.3937		860.536.4916

To be released to:

Specific reason for requested information to be released:

I understand that I have the right to revoke this authorization in writing at any time.

SIGNATURE OF PATIENT OR GUARDIAN

DATE

PRINT NAME OF PATIENT