Deutscher Rottinghaus Oxandale

- *Chris A. Deutscher, O.D.*
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AUTHORIZATION TO RELEASE MEDICAL RECORDS

I _____, D.O.B. _____, hereby authorize and request Drs. Deutscher, Rottinghaus & Oxandale Optometry to (_____**Send my records to) OR (**_____**Receive my records from)**

_____

Dr's office we are sending to or receiving from?

_____

(Address)

_____ _____

(FAX #) **(Phone #)**

The following information is needed.

_____ Clinical and/or Optometric Records

_____ Spectacle Prescription Only

_____ CL Prescription Only

_____ Other (specify) _____

I understand that this consent (unless revoked in writing) expires 90 days from signature date unless otherwise specified as follows:

_____

Signature **Date**

_____

Witness Relationship

This information has been disclosed to you from records in which confidentiality is protected by federal law. Federal regulations (42 CFR part 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of information is not sufficient for this purpose.

General 32 (Revised 06/16/2026)