



**Optical Expressions**

12422 Olive Blvd  
Creve Coeur, MO 63141  
Tel: (314) 579-1179  
Fax: (314) 514-7413

**Optical Expressions Clayton**

7718 Forysth  
Clayton, MO 63105  
Tel: (314) 721-0909  
Fax: (314) 721-7413

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**Authorization for Release of Records to Another Provider**

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Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City, State Zip: \_\_\_\_\_

I authorize Optical Expressions to release health information identifying me under the following conditions:

- Description of information to be released:

\_\_\_\_\_  
\_\_\_\_\_

- To whom this information is being released:

\_\_\_\_\_

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Signature

Date

If signing as a personal representative of the patient, describe the relationship to the patient and source of authority to sign this form:

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Relationship to Patient

Print Name