Vision Park
FAMILY EYE CARE

BETH TRIEBEL, OD
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AUTHORIZATION OF RELEASE INFORMATION

Patient Name: _____ DOB _____

I authorize Vison Park Family Eye Care to release my medical information to:

_____ _____

Name Relationship

_____ _____

Phone Fax

The Disclosure is for the following purpose(s):

____ Medical Records ____ Prescription

____ Billing and Insurance ____ Other_____

The release expires on ___/____/____ or one year from the date signed.

I understand that I may refuse to sign this authorization or revoke this authorization at any time. I understand that my revocation or refusal to sign this authorization will not affect my ability to obtain health care services unless the services are at the request of the party to whom the protected health information will be disclosed. I also understand that if I revoke, the information described above may be re-disclosed and will no longer be protected by the regulations.

_____ _____

Patient Signature or Patient's Legal Representative Date

Printed name of patient's legal representative: _____

Relationship to the patient: _____