Vision Park
FAMILY EYE CARE

BETH TRIEBEL, OD
WENDY MULLER, OD
MELISSA BILLINGS, OD

2699 86TH STREET • URBANDALE, IA 50322 • 515-270-2490

640 S. 50TH STREET • SUITE 2180 • WEST DES MOINES, IA 50265 • 515-225-8667

AUTHORIZATION OF RELEASE INFORMATION

Patient Name: _____DOB___/___/___ SS# _____

I authorize Vision Park Family Eye Care

To _____Release to _____Obtain from _____Verbally exchange with

_____

Name Address

_____

Phone Fax

Specific description of information (including date(s) of service):

_____

_____

_____

The disclosure is for the following purpose(s):

_____

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 servicers 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.

_____ _____

Signature of patients or patient's legal representative Date

Printed name of patient's legal representative: _____

Relationship to the patient:_____